UNITED STATES DISTRICT COURT FOR THE 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,

Plaintiffs,

v.

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

Defendants.

Case No. 0:24-cv-03043-LMP-DTS

DECLARATION OF KAI RICHTER

- I, Kai Richter, declare and state as follows:
- 1. I am Of Counsel at Cohen Milstein Sellers & Toll PLLC and am one of the attorneys representing Plaintiffs in the above-captioned action. I submit this transmittal declaration in opposition to Defendant Wells Fargo & Company's Motion to Dismiss.
 - 2. Attached hereto are true and correct copies of the following documents:

Exhibit 1: Appendix B from Wells Fargo Benefits Book, effective January 1, 2024, downloaded from https://teamworks.wellsfargo.com/pdf/Benefits_Book.pdf;

Exhibit 2: Are You NADAC Ready? Staying Ahead of the Drug Pricing Landscape, Modern HealthcareTechnology Blog (Sept. 27, 2023), https://blog.cervey.com/are-you-nadac-ready;

Exhibit 3: Joshua P. Cohen, *Capital Rx Aims To Disrupt The PBM Market*, Forbes (Feb. 3, 2022),

https://www.forbes.com/sites/joshuacohen/2022/02/02/capital-rx-aims-to-disrupt-the-pbm-market/;

Exhibit 4: Paige Minemyer, Express Scripts Embraces Cost-Plus Pricing, Fierce Healthcare (Nov. 14, 2023),

https://www.fiercehealthcare.com/payers/express-scripts-embraces-cost-plus-pricing-new-clearnetwork-model;

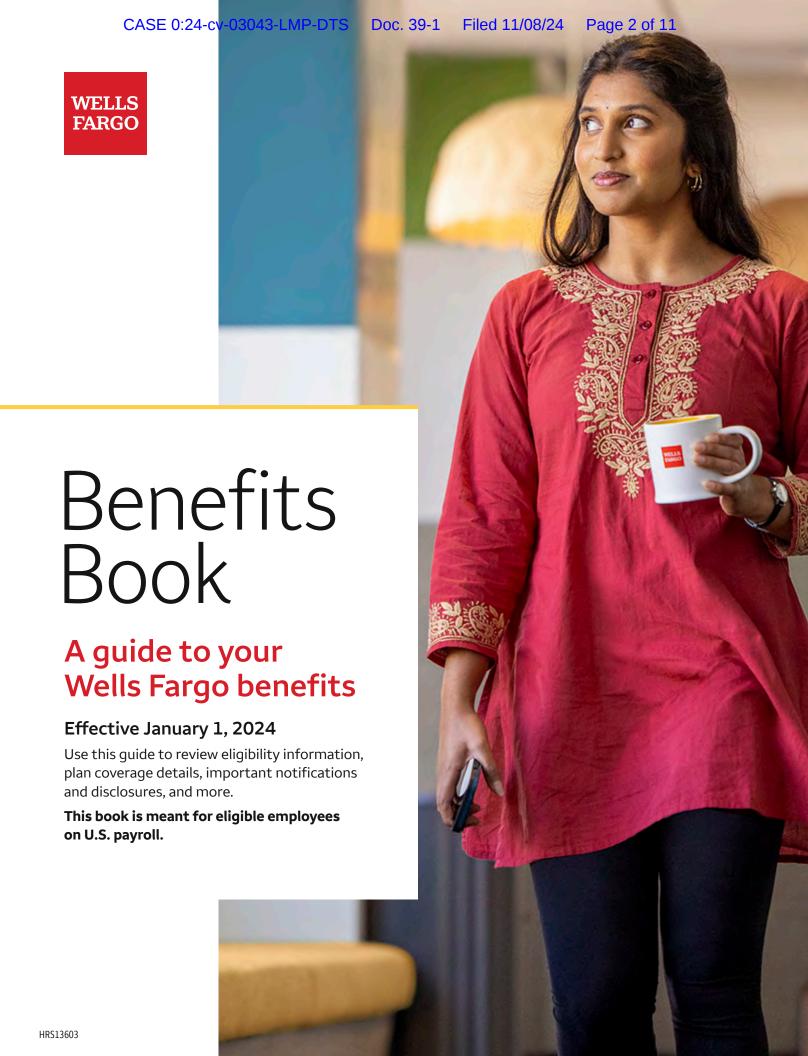
Exhibit 5: Form 5500 for the Wells Fargo & Company Health Plan (for Eligible Active Employees & their Dependents) for the plan year ending December 31, 2019; and

Exhibit 6: Form 5500 for the Wells Fargo & Company Health Plan (for Eligible Active Employees & their Dependents) for the plan year ending December 31, 2022.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: November 8, 2024 /s/ Kai H. Richter
Kai H. Richter

EXHIBIT 1



Appendix B: Important Notifications and Disclosures

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Your rights under ERISA

All of the Wells Fargo-sponsored plans listed in the "ERISA plans sponsored by Wells Fargo" table starting on page B-7, are subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA gives you rights as a participant in these plans.

Receive information about your plan and benefits

As a participant in these ERISA-covered plans, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to:

- Examine without charge at the plan administrator's office and at other specified locations such as work sites, all documents governing the plan, including copies of insurance contracts and the latest Annual Report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration of the U.S. Department of Labor.
- Obtain by written request to the plan administrator, copies
 of documents governing the operation of the plan, including
 insurance contracts and copies of the latest Annual Report
 (Form 5500 Series) and updated Summary Plan Description.
 The plan administrator may make a reasonable charge for
 the copies.
- Receive a summary of the plan's annual financial report.
 The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue group health plan coverage

You may be entitled to continue health care coverage for yourself, your spouse, your domestic partner, or your dependents if there is a loss of coverage under a Wells Fargosponsored group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review "Appendix E: Continuing Coverage Under COBRA" in this Benefits Book for the rules governing your COBRA continuation rights.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon people who are responsible for the operation of employee benefit plans. The people who operate the plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and all other plan participants and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcing your rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and you have exhausted the claims procedure for the plan, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay court costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about rights under ERISA, or if you need help in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries Employee Benefits Security Administration U.S. Department of Labor 200 Constitution Avenue, N.W. Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or by visiting https://www.dol.gov/ebsa.

Other notifications for group health plan coverage

If you participate in a self-insured group health plan sponsored by Wells Fargo, your coverage must comply with certain federal laws, including the Women's Health and Cancer Rights Act of 1998 and the Newborns' and Mothers' Health Protection Act. If you participate in a fully insured plan (HMO), the Women's Health and Cancer Rights Act of 1998 and the Newborns' and Mothers' Health Protection Act may not apply if your state has a law with certain protections for hospital stays following mastectomies or childbirth.

If you are accessing the *Benefits Book* electronically and you want a paper copy of any one or all of the following notices, you may print the applicable page from the online version. You may also request that a *Benefits Book* be sent to you free of charge by submitting a benefits material request on HR Services & Support.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the individual's attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications resulting from the mastectomy (including lymphedema)

These mastectomy-related benefits are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your Wells Fargo-sponsored medical plan option. Applicable deductibles and coinsurance amounts are listed on the plan's summary of benefits and coverage and in the summary plan description. If you would like more information on WHCRA benefits, call the claims administrator for your plan; or refer to the phone number on your plan ID card.

The Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not,

under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Notice of special enrollment rights under HIPAA

If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in a medical benefit option under the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents), or the UHC Global medical plan option for U.S. expats under the Wells Fargo & Company International Plan (if applicable), if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Lastly, you are eligible to enroll in a medical benefit option under the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents) outside of the open enrollment period if: (a) you or your eligible dependent is enrolled in Medicaid or the state's Children's Health Insurance Program (CHIP) and coverage is terminated due to a loss of eligibility for coverage under Medicaid or CHIP, or (b) you or your eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. You must request enrollment within 60 days after your Medicaid or CHIP coverage is terminated due to a loss of eligibility or you become eligible for a premium assistance subsidy, as applicable.

To request special enrollment or obtain more information, please refer to the "Special enrollment rights" section in "Chapter 1: Eligibility, Enrollment, and More" of this *Benefits Book*, or contact Employee Care during normal business hours at 1-877-HRWELLS (1-877-479-3557), option 2.

Patient Protection Notice

The medical plans indicated below may require or allow the designation of a primary care provider (PCP), including a pediatrician for your children.

PCP designation and referral requirements

- This plan **requires** the designation of a PCP but no referrals to see a specialist:
 - Copay Plan with HRA administered by UnitedHealthcare (UHC)
 - Select a Tier 1 Nexus ACO provider or Tier 2
 UnitedHealthcare Choice Plus Network provider as your PCP. Note: When you see a Tier 1 provider, you will generally have lower out-of-pocket costs than if you see a Tier 2 provider.
 - If you fail to designate a PCP, UHC will designate one for you.
- These plans **require** the designation of a PCP **and require** referrals to see a specialist:
 - Local Copay Plan with HRA administered by UHC
 - o Charter Network in Illinois (Chicago area)
 - o Charter Networks in Texas
 - Local Copay Plan with HRA administered by Centivo in the following locations:
 - o Iowa (Des Moines area)
 - Connecticut
 - New Jersey
 - New York
 - o Pennsylvania

For the Copay Plan with HRA and the Local Copay Plan with HRA administered by UHC, if you fail to designate a PCP, UHC will designate one for you. You may change your PCP selection at any time.

For the Local Copay Plan with HRA administered by Centivo, if you fail to designate a PCP, a Centivo representative will reach out to you to advise you how to designate a PCP. You may change your PCP selection at any time. **Note:** For Centivo in any location, if you do not have a designated PCP to provide your care or give you a referral to another in-network provider, coverage will be limited to emergency services and services for which you do not need a referral (see the "Referrals" section on page 2-13 of "Chapter 2: Medical Plans" for more information).

For the plans listed above, you have the right to designate any PCP who participates in the claims administrator's applicable network and who is available to accept you or your family members as patients. For children, you may designate a pediatrician as their PCP. For information on how to select a primary care provider, and for a list of the participating primary care providers, call Included Health, at 1-833-200-7683 or contact the claims administrator (see the contact information in the "ERISA plans sponsored by Wells Fargo" table starting on page B-7.) You may change your PCP selection at any time.

The following medical plans do not have any PCP requirements and do not require referrals, but it is recommended that you establish a medical care relationship with a PCP in your claims administrator's applicable network who is familiar with your health needs for continuity of care:

- HSA Plan administered by Anthem BCBS
- · HSA Plan administered by UnitedHealthcare
- Local Copay Plan with HRA administered by Anthem BCBS
- Local Network Plan with HRA administered by UHC:
 - Fairview ACO Core Network in Minnesota (Minneapolis/St. Paul area)
 - Banner ACO Network in Arizona (Phoenix area)
- HMO Kaiser
- Kaiser POS Added Choice Hawaii
- · Flex HDHP administered by Anthem BCBS
- Flex HDHP administered by UnitedHealthcare

Obstetrical or gynecological care

For all of our medical plan options, you do not need prior authorization from the claims administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the applicable claims administrator's network who specializes in obstetrics or gynecology. The chosen health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a preapproved treatment plan or procedures for making referrals. Note: If you are enrolled in the Local Network Copay Plan, and Kaiser medical plan options, you must use a network provider. For a list of participating (network) health care professionals who specialize in obstetrics or gynecology under your medical plan, call Included Health, at 1-833-200-7683 or contact the applicable claims administrator (see the contact information in the "ERISA plans sponsored by Wells Fargo" table starting on page B-7) or refer to the information on your plan ID card.

Plan information

Employer identification number

The IRS has assigned the employer identification number (EIN) 41-0449260 to Wells Fargo & Company. Use this number if you correspond with the government about the Wells Fargo-sponsored plans. In addition, Wells Fargo & Company has assigned a three-digit plan identification number to each plan. The "ERISA plans sponsored by Wells Fargo" table starting on page B-7 shows each plan's official name, the type of plan, the plan's number, and the phone number of any claims administrator, HMO, or insurer.

Plan sponsor

Wells Fargo & Company is the plan sponsor for all of the plans listed in the "ERISA plans sponsored by Wells Fargo" table starting on page B-7. Please use the address below for any correspondence to the plan sponsor and include the plan name and plan number in your correspondence:

Wells Fargo & Company MAC A0101-121 420 Montgomery St. San Francisco, CA 94104

Plan administrator

The plan administrator for all plans listed in the "ERISA plans sponsored by Wells Fargo" table starting on page B-7, for purposes of ERISA §3(16)(A), is Wells Fargo & Company's: Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), and Head of Benefits (or the functional equivalent title of the most senior position in Human Resources over benefit plans and programs other than the Head of Human Resources and Head of Total Rewards), each of whom, acting individually or jointly, may take action as the plan administrator, or its or their authorized delegate. The plan administrator has full discretionary authority to administer and interpret those plans. The plan administrator may delegate duties and authority to others to accomplish those duties.

The plan administrator's address is:

Plan Administrator Wells Fargo & Company MAC N9310-110 550 S. 4th St. Minneapolis, MN 55415

You may also contact Employee Care by accessing chat, submitting an inquiry through HR Services & Support, or by phone at 1-877-HRWELLS (1-877-479-3557), option 2

The insurer of each "insured" ERISA plan sponsored by Wells Fargo & Company has sole and complete discretionary authority to administer and interpret the provisions of the plan it insures. Please see the "ERISA plans sponsored by Wells Fargo" table starting on page B-7 to determine whether a plan is insured and for corresponding contact information for the applicable insurer or claims administrator.

Agent for service

Wells Fargo & Company's Corporate Secretary, at the address below, is the designated agent for service of legal process for the plans. You can also serve legal process on the plan administrator at the address listed above.

Corporate Secretary Wells Fargo & Company 30 Hudson Yards Floor 61 New York, NY 10001-2170

For information about service for legal process upon a plan's HMO, insurer, or claims administrator, contact the HMO, insurer, or claims administrator as noted in the "ERISA plans sponsored by Wells Fargo" table starting on page B-7.

No legal action can be taken against any party with regard to a claim for benefits under the plans until the applicable claims and appeals procedures described in this *Benefits Book* have been exhausted. Any suit for benefits must be brought within one year of the date of the final appeal determination (or deemed final determination) or three years from the date the service or treatment was provided, whichever is earlier, unless otherwise noted in the applicable chapter of this *Benefits Book*.

No legal action can be taken against any party with regard to a dispute of eligibility or enrollment until the process described in "Enrollment and eligibility disputes" has been completed, as detailed in "Chapter 1: Eligibility, Enrollment, and More." Any legal action must be brought within one year of the date of the final determination issued by Corporate Benefits on behalf of the plan administrator.

Plan trustee

The plan trustee for the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents) and the Wells Fargo & Company Short-Term Disability Plan is:

Delaware Charter Guarantee & Trust Company d/b/a Principal Trust Company 1013 Centre Road, Suite 300 Wilmington, DE 19805-1265

Plan year

Financial records for the plans are kept on a calendar year basis, also known as the "plan year," beginning on January 1 and ending the following December 31.

Disclosure about health savings accounts

Wells Fargo & Company sponsors and maintains high-deductible health plans for plan participants and their eligible dependents that are compatible with a health savings account ("HSA"). However, the HSA itself is not part of any ERISA-covered employee benefit plan sponsored or maintained by Wells Farqo & Company or any of its subsidiaries or affiliates.

Further, it is Wells Fargo & Company's intention to comply with the U.S. Department of Labor issued guidance, which specifies that an HSA is not subject to ERISA when the employer's involvement is limited. Establishment of an HSA is completely voluntary on your part.

- Wells Fargo & Company does not limit your ability to move your funds to another HSA or impose conditions on usage of HSA funds beyond those permitted under the Internal Revenue Code. However, Wells Fargo & Company will only support payroll deductions or provide funding of health and wellness dollars and other employer contributions, if applicable, for HSAs opened through Wells Fargo's HSA vendor, Optum Bank.
- Wells Fargo & Company does not make or influence the investment decisions with respect to funds contributed to an HSA. Available HSA investment funds are not guaranteed and you could lose money.
- Wells Fargo & Company does not represent that the HSA is an ERISA-covered employee benefit plan established or maintained by Wells Fargo & Company or any of its subsidiaries or affiliates.

A health savings account is an individually owned account. The health savings account will continue to be your account, even if you leave Wells Fargo or change health plan coverage.

Participating employers

The plans generally cover employees of Wells Fargo & Company and those subsidiaries and affiliates of Wells Fargo & Company that have been authorized to participate in the plans. These participating Wells Fargo companies are called participating employers. Participants and beneficiaries in the plans may receive, on written request, information as to whether a particular subsidiary or affiliate is a participating employer of a particular plan, and if it is, the participating employer's address. To request a complete list of participating employers in the plans, write to the applicable plan administrator.

For the address of the plan administrator for the plans covered in this *Benefits Book*, see the "<u>Plan administrator</u>" section starting on page B-5.

Future of the plans

Wells Fargo & Company reserves the unilateral right to amend, modify, or terminate any of its benefit plans (or benefit plan options), programs, policies, or practices at any time, for any reason, with or without notice. Any such amendment, modification, or termination may apply to both current and future participants and their dependents and beneficiaries.

Plan amendments

Wells Fargo & Company, by action of its Board of Directors, the Human Resources Committee of the Board of Directors, or that of a person so authorized by resolution of the Board of Directors or the Human Resources Committee, may amend the plans at any time, for any reason, with or without notice. In addition, Wells Fargo & Company's: Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), or their delegate may amend the plans to comply with changes in applicable law, add or amend exhibits to the plans, or make changes in the administration or operation of the plans (subject to any limitations specified in the applicable resolutions adopted by the Board of Directors of the Company).

Plan termination

Wells Fargo & Company may terminate any plan at any time, for any reason, with or without notice by action of Wells Fargo's Board of Directors. Wells Fargo & Company, by written action of its President, Chief Executive Officer, Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), or their delegate (subject to any limitations specified in applicable resolutions adopted by the Board of Directors of the Company), may terminate any plan at any time, for any reason, with or without notice, as it applies to any participating employer.

ERISA plans sponsored by Wells Fargo

Plan name	Plan coverage option	Plan number	Service provider or insurer
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents) ¹	Copay Plan with Health Reimbursement Account (HRA)* (Self-insured²)	537	Medical UnitedHealthcare 1-800-842-9722
			Prescriptions Express Scripts 1-855-388-0352
	* Including Out of Area Coverage		HRA claims HealthEquity 1-877-924-3967
Wells Fargo & Company Health Plan for Eligible Active Employees and Their Dependents)¹	Health Savings Account (HSA) Plan*.3 (Self-insured²)	537	Medical Anthem Blue Cross Blue Shield 1-866-418-7749
			UnitedHealthcare 1-800-842-9722
	* Including Out of Area Coverage		Prescriptions Express Scripts 1-855-388-0352
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents) ¹	Local Copay Plan with Health Reimbursement Account (HRA) (Self-insured²)	537	Medical Anthem Blue Cross Blue Shield 1-866-418-7749
			Centivo 1-833-666-1506
			UnitedHealthcare 1-800-842-9722
			Prescriptions Express Scripts 1-855-388-0352
Wells Fargo & Company Health Plan for Eligible Active Employees and Their Dependents)¹	Flexible High-Deductible Health Plan (Self-insured²)	537	Medical Anthem Blue Cross Blue Shield 1-866-418-7749
			UnitedHealthcare 1-800-842-9722
			Prescriptions Express Scripts 1-855-388-0352
Wells Fargo & Company Health Plan for Eligible Active Employees and Their Dependents) ¹	HMO — Kaiser California (Insured ⁴) (Northern and Southern California)	537	Kaiser Permanente 1-800-464-4000
Vells Fargo & Company Health Plan for Eligible Active Employees and Their Dependents) ¹	HMO — Kaiser Colorado (Insured⁴)	537	Kaiser Permanente 1-800-632-9700
Vells Fargo & Company Health Plan for Eligible Active Employees and 'heir Dependents)'	POS Kaiser Added Choice — Hawaii (Insured⁴)	537	Kaiser Hawaii 1-800-966-5955
Nells Fargo & Company Health Plan for Eligible Active Employees and	HMO — Kaiser Mid-Atlantic (Insured⁴)	537	Kaiser Permanente D.C. area
Their Dependents) ¹			301-468-6000
			Outside D.C. area 1-800-777-7902

^{1.} This plan will be known as the Wells Fargo & Company Health Plan (or the Health Plan) throughout this Benefits Book.

^{2. &}quot;Self-insured" means benefits are paid for by the plan through a trust. The identified service provider provides claims administrative services and is the claims and appeals fiduciary.

^{3.} Your individual HSA is not part of the ERISA plan and is not sponsored by Wells Fargo. See "Appendix C: Health Savings Accounts" for more information about your HSA

 $^{{\}bf 4.~`Insured"}~means~benefits~are~fully~insured~and~paid~for~by~the~insurer,~which~may~be~an~HMO.$

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Plan name	Plan coverage option	Plan number	Service provider or insurer
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents) ¹	HMO — Kaiser Northwest (Insured⁴)	537	Kaiser Permanente 1-800-813-2000 Portland metro area 503-813-2000
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents) ¹	HMO — Kaiser Washington (Insured⁴)	537	Kaiser Permanente 1-888-630-4636 Seattle 206-630-4636
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents) ¹	Delta Dental: Standard and Enhanced (Self-insured²)	537	Delta Dental of Minnesota 1-877-598-5342
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents) ¹	Vision Service Plan (VSP) (Self-insured²)	537	VSP 1-877-861-8352
Wells Fargo & Company International Plan	UnitedHealthcare Global — Expatriate Insurance (Insured⁴)	538	UnitedHealthcare Global 1-877-844-0280 or 763-274-7362
Wells Fargo & Company Health Care Flexible Spending Account Plan	Full-Purpose Health Care Flexible Spending Account	509	HealthEquity 1-877-924-3967
Wells Fargo & Company Health Care Flexible Spending Account Plan	Limited Dental/Vision Flexible Spending Account	509	HealthEquity 1-877-924-3967
Wells Fargo & Company Short-Term Disability Plan	Short-Term Disability Plan (STD) (Self-insured²)	517	Lincoln Financial Group 1-866-213-2937
Wells Fargo & Company Short-Term Disability Top-Up Plan	Short-Term Disability Top-Up Plan (Self-insured)	523	Lincoln Financial Group 1-866-213-2937
Wells Fargo & Company Long-Term Disability Plan	Long-Term Disability Plan (LTD) (Insured ⁴)	505	Lincoln Financial Group 1-866-213-2937
Wells Fargo & Company Legal Services Plan	Legal Services Plan (Insured⁴)	535	ARAG Insurance Company 1-800-299-2345
Wells Fargo & Company Life Insurance Plan	Basic Term Life Insurance coverage (Insured ⁴)	506	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Life Insurance Plan	Dependent Term Life Insurance coverage (Insured⁴)	506	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2

^{1.} This plan will be known as the Wells Fargo & Company Health Plan (or the Health Plan) throughout this Benefits Book.

^{2. &}quot;Self-insured" means benefits are paid for by the plan through a trust. The identified service provider provides claims administrative services and is the claims and appeals fiduciary.

^{4. &}quot;Insured" means benefits are fully insured and paid for by the insurer, which may be an HMO.

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Plan name	Plan coverage option	Plan number	Service provider or insurer
Wells Fargo & Company Life Insurance Plan	Optional Term Life Insurance coverage (Insured ⁴)	506	Metropolitan Life Insurance Company (MetLife)
			Employee Care Chat or submit an inquiry through HR Services & Support Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Life nsurance Plan	Spouse/Partner Optional Term Life coverage (Insured ⁴)	506	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Business Travel Accident Plan	Business Travel Accident (BTA) (Insured ⁴)	503	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Accidental Death and Dismemberment Plan	Accidental Death and Dismemberment (AD&D) (Insured⁴)	518	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Optional Accident Insurance Plan	Optional Accident Insurance Plan (Insured⁴)	548	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Wells Fargo & Company Critical Ilness Insurance Plan	Basic Critical Illness Insurance coverage (Insured ⁴)	547	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Wells Fargo & Company Critical Ilness Insurance Plan	Optional Critical Illness Insurance coverage (Insured⁴)	547	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320

Appendix B: Important Notifications and Disclosures

EXHIBIT 2



Contact Us

Close

340B

340B SPLIT BILL

340B CONTRACT PHARMACY

HOSPITAL

DSCSA TRACK AND TRACE

PATIENT ASSISTANCE

SPECIALTY PHARMACY

PBM

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Are You NADAC Ready? Staying Ahead of the Drug Pricing Landscape

Published by Cervey on Sep 27, 2023 4:58:21 PM

Interested in a deeper understanding of NADAC pricing as it relates to the drug pricing landscape? This paper provides a look into the methodology behind NADAC calculation, its application in various healthcare programs, as well as how it compares to other pricing methodologies such as Average Wholesale Price (AWP), Maximum Allowable Cost (MAC), and Wholesale Acquisition Cost (WAC). Additionally, it explores the reasons for NADAC's growing traction in the market, including its role in reimbursement negotiations, cost management, formulary management, reimbursement policy alignment, pricing transparency, and industry trends.

What Is NADAC Pricing?

The National Average Drug Acquisition Cost (NADAC) represents the average price that retail community pharmacies pay to acquire prescription drugs, including both brand and generic drugs, from wholesalers. NADAC pricing is calculated by collecting data from participating pharmacies across the country and aggregating it to determine the average acquisition cost for each drug. The program was initiated by the Centers for Medicare and Medicaid Services (CMS) to address concerns about the lack of transparency and consistency in drug pricing, particularly for Medicaid reimbursement purposes.

Understanding NADAC Calculation

NADAC pricing involves a multi-step process:

- Data Collection: CMS collects pricing data voluntarily reported by retail community pharmacies.
 Participating pharmacies provide information on drug names, strengths, package sizes, and the prices they pay for acquiring medications.
- 2. **Data Aggregation**: The collected pricing data is aggregated and organized by CMS, categorizing it based on active ingredients, strength, dosage form, and route of administration. This step helps identify pharmaceutical equivalents within drug groups.
- 3. **Methodology Application:** CMS applies a specific calculation methodology to determine NADAC for each drug. The methodology considers factors such as reported prices, the number of reporting pharmacies, sales volume, and necessary exclusions or adjustments.
- 4. **Average Calculation:** Using the collected data and applied methodology, CMS calculates the average acquisition cost for each drug. This calculated average reflects the estimated price that retail pharmacies pay to acquire specific medications.
- 5. **Price Publication:** CMS publishes the calculated NADAC prices regularly, making them publicly accessible to healthcare providers, policymakers, payers, and the public.

Expanding Application of NADAC Pricing

Initially designed as a reference point for Medicaid reimbursement rates, NADAC pricing has gained prominence and expanded its application over time. Its usage now extends beyond Medicaid to other federal and state healthcare programs, commercial payers, and pharmacy benefit managers (PBMs). While PBMs themselves are not typically responsible for reporting NADAC data, they may play a role in ensuring accurate data collection and transmission among pharmacies, manufacturers, and wholesalers.

Comparing NADAC to Other Pricing Methodologies

NADAC pricing differs significantly from traditional pricing methodologies such as Average Wholesale Price (AWP), Maximum Allowable Cost (MAC), and Wholesale Acquisition Cost (WAC). Here's a comparative analysis:

- 1. AWP (Average Wholesale Price): AWP has historically served as a benchmark for drug pricing, representing the price at which wholesalers sell drugs to pharmacies. However, it often includes an inflated markup.
- 2. MAC (Maximum Allowable Cost): MAC sets maximum reimbursement limits for generic drugs, typically based on the cost of the lowest-priced equivalent drug. It lacks transparency in pricing methodology.
- 3. WAC (Wholesale Acquisition Cost): WAC represents the price at which drug manufacturers sell products to wholesalers, excluding discounts or rebates. It may not reflect actual market prices due to separate negotiations.

In contrast, NADAC aims to provide a closer estimate of real-world acquisition costs, promoting transparency and standardized pricing benchmarks.

Factors Driving NADAC's Traction in the Market

Several factors contribute to NADAC's growing influence in the PBM industry and healthcare at large:

- Reimbursement Negotiations: NADAC serves as a benchmark for the average acquisition cost of
 prescription drugs paid by retail community pharmacies. PBMs use NADAC data to negotiate fair
 reimbursement rates with pharmacies, aligning them with market prices.
- 2. **Cost Management:** PBMs are responsible for managing pharmacy benefit costs. Monitoring NADAC pricing trends enables PBMs to evaluate drug pricing competitiveness and identify cost-saving opportunities.
- 3. **Formulary Management:** NADAC data helps PBMs assess the cost-effectiveness of different drugs for formulary decision-making.
- 4. Reimbursement Policy Alignment: CMS uses NADAC to inform reimbursement rates for federal and state healthcare programs. PBMs need to ensure their reimbursement aligns with CMS guidelines for regulatory compliance.

CASE 0:24-cv-03043-LAMPY-DDTADAC REDAY? SIGNING AN EARLY BOOK LEVEL LAND CONTROL OF 5

- 5. **Pricing Transparency:** NADAC promotes transparency in drug pricing information. PBMs benefit from transparent pricing data, enabling them to negotiate fairly and provide transparency to clients, building trust and accountability.
- 6. **Industry Trends:** The healthcare industry's focus on drug pricing transparency and cost containment efforts has led to NADAC's rising prominence. Regulatory laws and mandates are driving the adoption of NADAC pricing as a standardized benchmark.

Regulatory Laws and Trends

Several states have enacted or proposed legislation related to NADAC pricing. Examples include:

- West Virginia House Bill 2022-63: This law mandates that PBMs may not reimburse pharmacies for prescription drugs or pharmacy services at an amount less than NADAC, plus a professional dispensing fee.
- **Georgia Code 33-64-91:** PBMs in Georgia are required to file NADAC pricing reports annually, ensuring transparency and compliance.
- Other Enhanced Reporting Requirements: Several states, including California, Ohio, Maryland, and Louisiana, have proposed or implemented enhanced NADAC pricing reporting requirements.

Conclusion

NADAC pricing is gaining traction in the PBM industry due to its role in pricing transparency, reimbursement negotiations, cost management, formulary management, regulatory compliance, and alignment with industry trends. It offers a standardized benchmark for drug pricing, promoting fairness and transparency in the healthcare system.

As the healthcare industry continues to focus on drug pricing transparency and cost containment, NADAC pricing is poised to play an increasingly significant role in shaping pricing decisions and reimbursement strategies for PBMs, health insurance plans, employers, and other healthcare stakeholders.

For PBMs and other entities involved in the management of pharmacy benefits, understanding NADAC pricing and its implications is crucial for remaining competitive, compliant with regulatory requirements, and meeting the demands of clients and members. As NADAC pricing continues to evolve and gain prominence, staying informed and adaptable is essential for success in the evolving drug pricing landscape.

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TAGS: ADJUDICATOR, PBM, NADAC, DRUG PRICING

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EXHIBIT 3

FORBES > INNOVATION > HEALTHCARE

Capital Rx Aims To Disrupt The PBM Market

Joshua P. Cohen Senior Contributor ① *Joshua Cohen is a Boston-based writer who covers health policy.*



Feb 2, 2022, 10:02am EST

Updated Feb 3, 2022, 10:27am EST

This article is more than 2 years old.



The start-up PBM Capital Rx is prying open the black box of prescription drug pricing. GETTY

For now, the political heat is off traditional pharmacy benefit managers (PBMs), as the Biden Administration rescinded President Trump's executive order that would have forced PBMs to pass through rebates to Medicare beneficiaries at the point of sale (pharmacy). And, while a Centers for Medicare and Medicaid Services (CMS) proposal would force Medicare Part D (outpatient drug) price concessions to be applied at the point of sale, these price concessions would not include rebates.

In lieu of executive and legislative policy changes that would have increased transparency and rebate pass-through, the marketplace is evolving. Start-ups are aiming to disrupt the PBM and pharmacy space.

Capital Rx, for example, is the nation's fastest-growing PBM. The company serves hundreds of thousands of covered lives. It grew by 400% in 2020, and doubled in size in 2021. Matt Gibbs, President of Commercial Markets, projects that Capital Rx will have close to one million covered lives by the end of 2022.

Capital Rx is a PBM that manages prescription drug benefits on behalf of unions, health systems, health plans, employers, and government entities. The company has approximately 160 clients.

In September 2019, Capital Rx launched its Clearinghouse Model, a novel pricing framework. The Clearinghouse Model itemizes the actual unit costs of prescription drugs, based on the National Average Drug Acquisition Cost (NADAC). The NADAC is maintained by CMS, and is derived from surveys of actual acquisition costs of prescription drugs among retail pharmacies.

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By Amy Danise Editor

Capital Rx uses NADAC prices rather than proprietary rebates off of average wholesale price or wholesale acquisition cost. While Capital Rx earns a flat fee per prescription claim processed, it does *not* engage in secretive rebating or spread pricing. The latter is a controversial practice in which PBMs reimburse the pharmacy less than the amounts health plans or employers reimburse PBMs, and PBMs pocket the difference.

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Importantly, Capital Rx says it offers contracts to its clients which reflect transparent, actual unit costs for all prescription drugs, and these unit costs will be the same for all customers. As Matt Gibbs explains, Capital Rx is prying open the black box of prescription drug pricing.

Capital Rx's adjudication platform, which it calls JUDI[™], is a platform that was designed to unify all PBM operations – from underwriting to claim adjudication to prior authorization to reimbursement – in one place to provide a comprehensive, more efficient care delivery system.

The company suggests that both $JUDI^{TM}$ and the Clearinghouse Model serve to free up resources away from negotiating complicated and opaque pricing deals, to tackling pharmaceutical cost management on behalf of clients.

In addition, in August of last year, the company launched the Capital Rx Advantage card, which brings what Gibbs calls "ethical, transparent drug pricing" to the prescription discount card market. By leveraging the NADAC pricing metric, coupled with a low per prescription processing fee of \$0.99, the card can save consumers up to 90% on their prescriptions. The card competes against other popular drug discount cards and claims to beat them on price 80% of the time.

Mainstream PBM market a tough nut to crack

11/7/24. 9:52 AM

Capital Rx's declared mission is to alter the PBM landscape by "changing the way prescription benefits are priced and administered in the U.S." This is a tall order, given that traditional PBMs have been around for decades, and as such have a stranglehold on the market. The "big three" - Optum Rx, CVS Caremark, and Express Scripts - currently control about 80% of the market. Their core activities include claims processing for more than 200 million covered lives, negotiating net prescription drug prices, formulary management, distributing medications through mail order and specialty pharmacies, and medication therapy management.

The rebate model is integral to conventional PBMs' negotiations of net prescription drug prices. Here, PBMs move market share towards certain products by designating them with preferred positions on the formulary, in exchange for rebates.

But, frustration with PBMs has been percolating for years. Employers have criticized PBMs for failing to disclose rebates they receive and for taking advantage of spread pricing; the difference between what PBMs pay pharmacies and what they charge employers and health plans for drugs.

Presently, employers don't know what PBMs reimburse the pharmacy, and the pharmacy doesn't know the amount PBMs bill employers. Differences between list prices - such as average wholesale price and wholesale acquisition cost - and net transaction prices create large spread opportunities for PBMs.

In turn, the practice of spread pricing enables price variability. Here, different employers pay different drug prices. Two patients in the same plan can be charged different prices

and different co-payments even if obtaining their prescriptions from the same pharmacy.

Ideally, in an efficient market there should be only one price of a given commodity or marketable product regardless of where it is traded. However, PBMs are able to manipulate prices and segment markets to their advantage. They appear to want to keep the healthcare market opaque. Perversely, opacity can help boost revenue and profits. It keeps consumers or purchasers in the dark, so it's not obvious to them where to find a better deal.

While employers have voiced displeasure with their dealings with PBMs, they mostly don't leave the relationship. However, this could change, with Capital Rx and others like it entering the market, as they embody a fundamentally different business model from prevalent PBM practices.

Capital Rx is still a small player in the PBM space, but it is expanding steadily with a nationwide footprint. Capital Rx's business model has the potential to shake things up in an industry that could use more visibility in the ways in which prescription drugs are priced.

Follow me on Twitter.



Joshua P. Cohen

Follow

Joshua Cohen covers healthcare policy, with a special focus on prescription drug pricing and reimbursement. Cohen writes about a wide variety of topics, including weight loss drugs, the Inflation Reduction Act, and even things like health risks related to climate change. Cohen is an independent healthcare analyst who works on a freelance basis on a variety of writing, research and teaching projects related to healthcare policy and pharmaceuticals. He has published extensively (hundreds of publications) in peer-reviewed journals and periodicals. Cohen has also presented his work at dozens of international and domestic (U.S.) conferences. Prior to being self-employed for the past seven plus years, he was an academic researcher at Tufts University for 18 years, a post-doc at the University of Pennsylvania for two years, a visiting fellow at Harvard University for two years and a Ph.d candidate and teaching assistant at the University of Amsterdam for four years. Read Less

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EXHIBIT 4

PAYERS

Express Scripts embraces cost-plus pricing with new ClearNetwork model

By Paige Minemyer

Nov 14, 2023 12:13pm

Express Scripts

pharmacy benefit management

Drug Prices

Pharmacies



The ClearNetwork launch builds on new programs unveiled earlier this year, Express Scripts said. (Express Scripts)

The country's largest pharmacy benefit manager is taking a page out of Mark Cuban's book.

Express Scripts on Tuesday announced (https://www.evernorth.com/articles/express-scripts-introduces-new-option-give-clients-maximum-simplicity-drug-pricing) the launch of its new pharmacy network option, ClearNetwork, which operates under a cost-plus model. In this approach, clients pay a "straightforward" acquisition cost for individual drugs as well as a small markup that covers dispensing and service costs.

ClearNetwork will be available to a range of clients including employers, government organizations and private payers.

"We are constantly innovating to provide our clients with new options that meet their needs and enable them to build custom pharmacy benefits that best support their plans and members," said Adam Kautzner, president of Express Scripts, in the release. "The Express Scripts ClearNetwork leverages our scale, relationships, and deep understanding of the pharmaceutical supply chain to create an easy-to-follow option for clients looking to simplify what they pay for prescription drugs, while supporting a seamless, convenient member experience."



(Evernorth)

The ClearNetwork model estimates the acquisition cost for individual medications using multiple established third-party benchmarks including predictive acquisition cost, national average drug acquisition cost and wholesale acquisition cost. The administrative fees are then added on top.

A flat fee is paid to the pharmacy for dispensing the medication, and then a second fee of 15% or less is used to cover Express Scripts' services and shared among participating pharmacies to ensure they have a "reasonable profit."

Express Scripts said it is making the model available to a "broad network" of more than 65,000 retail pharmacies. It will apply to each drug on a plan sponsor's list, including generics, branded products and specialty medications, beginning Jan. 1.

"This new model differs from other pricing options where Express Scripts negotiates discounts with pharmacies to meet guaranteed rates for clients," Kautzner said. "Express Scripts ClearNetwork is a simple pricing option that reinforces the value of our work to help consumers easily access the medications they need, while also shining a light on the root cause of high drug costs—drug manufacturers who set and raise prices."

The ClearNetwork launch builds of new programs unveiled earlier this year, Express Scripts said. The Phiarmacy benefit manager, for example, announced ClearCareRx, which offers a greater transparency for its clients.

Express Scripts also said programs like Copay Assurance, SafeGuardRx, Embarc Benefit Protection and the Patient Assurance Program saved customers a combined \$56 million in 2022.

Express Scripts pharmacy benefit management Drug Prices Pharmacies Finance Payers

Questex

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EXHIBIT 5

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Corporation				This	Form is Open to Pu Inspection	blic
Part I	Annual Report Ide	entification Information				
For calend	ar plan year 2019 or fisca	Il 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 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	2 months))	
C If the pl	an is a collectively-bargai	ned plan, check here			• []	
D Check b	oox if filing under:	X Form 5558	automatic extension	the	e DFVC program	
		special extension (enter description))			
Part II	Basic Plan Inform	ation—enter all requested information	on			
1a Name of plan WELLS FARGO & CO HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR DEPENDENTS)		1b	Three-digit plan number (PN) ▶	537		
			2,	1c	Effective date of pla 01/01/2011	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 Identifica Number (EIN) 41-0449260	tion	
WELLS FARGO & COMPANY			2c	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	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 CASE 0:24-cv-03043-LMP-DTS Doc. 39-5 Filed 11/08/24 Page 3 of 79

	Form 5500 (2019)	Pag	је 2				
3a	Plan administrator's name and address Same as Plan Sponsor				3b Administrator's EIN 41-0449260		
M M 55	ELLS FARGO & COMPANY CHAEL BRANCA AC N9310-110 0 S. 4TH STREET NNEAPOLIS, MN 55415				numbe	strator's telephone or 7-479-3557	
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin				4b EIN		
a c	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name Plan Name	m the last return	vrepo	ort:	4d PN		
5	Total number of participants at the beginning of the plan year				5	218107	
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	d (welfare plans	comp	plete only lines 6a(1),		2.0.0	
а(1) Total number of active participants at the beginning of the plan year				6a(1)	216100	
а(2) Total number of active participants at the end of the plan year				6a(2)	214116	
b	Retired or separated participants receiving benefits				6b	1882	
С	Other retired or separated participants entitled to future benefits				6c	0	
d	Subtotal. Add lines 6a(2) , 6b , and 6c				6d	215998	
е	Deceased participants whose beneficiaries are receiving or are entitled to receiving	ceive benefits			6e		
f	Total. Add lines 6d and 6e.				6f		
g	Number of participants with account balances as of the end of the plan year complete this item)	` •		•	6g		
h	Number of participants who terminated employment during the plan year with less than 100% vested				6h		
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer p	olans	complete this item)	7		
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9a	Plan funding arrangement (check all that apply) (1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) X Trust (4) General assets of the sponsor	9b Plan ber (1) (2) (3) (4)	nefit a	rrangement (check all the Insurance Code section 412(e)(3) Trust General assets of the s) insurance co	ontracts	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a		here	indicated, enter the num	ber attached.	(See instructions)	
а	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General (1) (2) (3) (4) (5) (6)	Scho	H (Financial Infor I (Financial Infor	mation – Sma ormation) der Information ting Plan Infor	n) rmation)	

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Receipt Confirmation Code_

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2019

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Pension Benefit Guaranty Corporation			- FDIOA (' 400/-\/0\			rm is Open to Public Inspection	
For calendar plan year 20	19 or fiscal pla	an year beginning 01/01/2019		and en	ding 12/31	/2019	
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		rning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
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	(c) NAIC	(d) Contract or	(e) Approximate no	umber of		Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) F	rom	(g) To
58-1592076	96237	10371	721		01/01/2019		12/31/2019
2 Insurance fee and comdescending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, b	rokers, and o	other persons in
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CASE 0:24-cv-03043-LMP-DTS Doc. 39-5 Filed 11/08/24 Page 6 of 79

Schedule A (Form 5500)	2019	Page 2 – 1		
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2 2122				

Schedule A (Form 5500) 2019

Page 3

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7f

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contra	acts with each carrier may	be treated	d as a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:			<u> </u>	
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				
	ď	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	I annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 -	ie participa	mon guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		(c) Callet (openly solon)	1 5(5)			
		•				
		(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			7e(5)	

f Balance at the end of the current year (subtract line 7e(5) from line 7d)

Р	art	Welfare Benefit Contract Information	on					
-		If more than one contract covers the same grouthe information may be combined for reporting employees, the entire group of such individual	up of employees of the purposes if such contr	acts are expe	érience-rated as a uni	t. Where co	ontracts cover individual	,
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	е	Temporary disability (accident and sickness)	브 ~	· <u></u>	Supplemental unem	ployment	h Prescription drug	
	i	Stop loss (large deductible)	X HMO contract	k _	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Ехре	erience-rated contracts:	F					
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium reserv	-	9a(3)		1		
		(4) Earned ((1) + (2) - (3))	F			. 9a(4)		
	b	Benefit charges (1) Claims paid	T .	9b(1)				
		(2) Increase (decrease) in claim reserves				01 (0)		
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
	_	(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (on a	, , , , , , , , , , , , , , , , , , ,	00(1)(A)				
		(A) Commissions	ħ	9c(1)(A) 9c(1)(B)				
		(B) Administrative service or other fees		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes	 	9c(1)(E)				
		(F) Charges for risks or other contingencies	i i	9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	·····			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These arr	nounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Ar	mount held to provide l	benefits after	retirement			
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not in	nclude amount entered	in line 9c(2) .)	. 9e		
10	No	nexperience-rated contracts:				_		
	а	Total premiums or subscription charges paid to carri	er			. 10a	299	93829
	b	If the carrier, service, or other organization incurred				401		
	Sne	retention of the contract or policy, other than reporte cify nature of costs.	d in Part I, line 2 above	e, report amo	unt	. 10b		
	Орс	ony flattere of costs.						
Р	art	V Provision of Information						
11	Dio	I the insurance company fail to provide any information	on necessary to comple	ete Schedule	А?	Yes	X No	
		he answer to line 11 is "Yes," specify the information						
			•					

SCHED	UL	Ε	Α
(Form	550	00)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2019

					_		
Pension Benefit Guaranty Co	orporation		e companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection	
For calendar plan year 20	19 or fiscal pla	n year beginning 01/01/2019		and en	ding 12/3	1/2019	
A Name of plan				B Three	e-diait		
WELLS FARGO & CO HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLODEPENDENTS)		LOYEES & THEIR		number (PN) •	537	
C Plan sponsor's name as shown on line 2a of Form 5500			D Employer Identification Number (EIN)				
WELLS FARGO & COMPANY			41-0449260				
		rning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		OF HAWAII					
	(a) NIAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac		(f)	From	(g) To
94-1340523	60053	35612	168		01/10/2019)	12/31/2019
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, b	orokers, and c	other persons in
(a) Total	amount of com	nmissions paid		(b) Total amount of fees paid			
		0	0		0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees v	were paid	
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees v	were paid	
						·	
(b) Amount of sales a	nd hase	F	Fees and other commissions paid				
commissions pa		(c) Amount		(d) Purpose	e	<u> </u>	(e) Organization code

CASE 0:24	4-CV-U3U43-LIMP-DTS	Doc. 39-5 Filed 11/08/24 Page 10 01 /	9	
Schedule A (Form 5500) 2019 Page 2 - 1				
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
· · ·				
		(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
osimilasiona para			0000	
(a) Nar	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
(h) Amount of color and trans		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with e	each carrier may be trea	ted as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
		tracts With Allocated Funds:		•	•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with the acc	quisition or 6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
_	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year		-	
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•	. , ,		
				7.70	
		(6)Total additions)
		Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	Deductions:	- (1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total doductions		7e(5	1
	f	(5) Total deductions			<i>)</i>
	1	Dalance at the end of the current year (Subtract line /e(3) from line /d)		/ 1	1

P	art	III Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	group of employees of the ing purposes if such cont	racts are expe	érience-rated as a unit	t. Where co	ontracts cover individual
8	Dan		dai contracts with each ca	aniei may be	ireated as a drift for pr	uiposes oi	пів тероп.
0		refit and contract type (check all applicable boxes)	b □ poured	• □	A Carlana		d □ 136. S
	а	X Health (other than dental or vision)	b Dental	c 🗌			d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)	_				_
		_ `' '/					
9	Ехр	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	l	· · ·			
		(3) Increase (decrease) in unearned premium res					
		(4) Earned ((1) + (2) - (3))	· · · · · · · · · · · · · · · · · · ·			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	······	<u></u>		9c(1)(H	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2).)	. 9e	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	1015243
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than reposits pattern of costs.				. 10b	
D		Provision of Information					
	art					.,	<u> </u>
11	Di	d the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No
12	lf t	the answer to line 11 is "Yes," specify the informati	on not provided.				

SCHED	U	LE	Α
(Form	5	500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Co	orporation	pursuant to	s are required to provide to ERISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	19 or fiscal pla	n year beginning 01/01/2019		and en	ding 12/31	/2019	
A Name of plan WELLS FARGO & CO H DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMPL	OYEES & THEIR	B Three	e-digit number (PN)	•	537
C Plan sponsor's name a		e 2a of Form 5500			yer Identifica -0449260	tion Number	(EIN)
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		COLORADO (d) Contract or	(e) Approximate no			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) F	rom	(g) To
84-0591617	95669	1095	2902		01/01/2019		12/31/2019
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, b	rokers, and o	ther persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of	f fees paid	
		0					0
3 Persons receiving com		ees. (Complete as many entrie			·		
		and address of the agent, broke	ees and other commissio		ions of fees v	vere paid	T
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose	Δ		(e) Organization code
commissions pa	lu	(d) / unodin		(a) 1 a 1pos			(c) organization odd
	(a) Name a	and address of the agent, broke	or other person to who	m commiss	ions or fees v	vere paid	
	(a) Name a	and address of the agent, broke	e, or other person to who	III COIIIIIIISS	ions of fees v	vere paiu	
(b) Amount of color as	nd book	Fe	ees and other commission	ns paid			
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

CASE 0:22	4-cv-03043-LMP-DTS	Doc. 39-5 Filed 11/08/24 Page 14 of /	9
Schedule A (Form 5500)	2019	Page 2 – 1	
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(a) ivai	ne and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of calca and have		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,		·	
(h) Amount of calca and has		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

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Schedule A (Form 5500) 2019

F	Part I		سنده و احداده			
		Where individual contracts are provided, the entire group of such individus this report.	ndual contra	acis with each camer may	be treated	as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Conti	racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		•	6d	
		Specify nature of costs				
	•	Type of contract: (1) \square individual policies (2) \square group deferred	d appuitu			
		Type of contract: (1) individual policies (2) group deferre	u armuny			
		(3) other (specify)				
				_		
		If contract purchased, in whole or in part, to distribute benefits from a termination				
7	Conti	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	ation guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year			1.5	
	•	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		b	70(0)			
		,				
		(6)Total additions			7c(6)	
	d ⁻	Total of balance and additions (add lines 7b and 7c(6))			7d	
	e 1	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(-) -			70(5)	
		(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

	art I	If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	group of employees of the ng purposes if such contr	acts are expe	erience-rated as a uni	t. Where co	ontracts cover individual
8	Bene	efit and contract type (check all applicable boxes)	_	_			_
	a 🔀	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у д 🗌	Supplemental unem	ployment	h Prescription drug
	ιĒ	Stop loss (large deductible)	j X HMO contract	k□	PPO contract		I Indemnity contract
	m	Other (specify)	, 🗀	Ц			
	L	Cities (specify)					
9	Expe	rience-rated contracts:					
Ŭ		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	•				
		(3) Increase (decrease) in unearned premium res		9a(3)			
		(4) Earned ((1) + (2) - (3))	-			9a(4)	
		Benefit charges (1) Claims paid	The state of the s				
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses	•	9c(1)(D)			
		(E) Taxes	1	9c(1)(E)			
		(F) Charges for risks or other contingencies					
		(G) Other retention charges				00/1//Ш	
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	a	Status of policyholder reserves at end of year: (1)	·			9d(1)	
		(2) Other reserves				9d(2)	
	е	(3) Other reserves				9d(3)	
10		nexperience-rated contracts:	n include amount entered	iii iiile 30(2) .)	. 9e	
		Total premiums or subscription charges paid to ca	arrier			. 10a	15308091
		If the carrier, service, or other organization incurr				100	1000001
		retention of the contract or policy, other than repo				. 10b	
		cify nature of costs.		-, · - - - · · · · · · · ·			· ·
P	art l	V Provision of Information					
11		the insurance company fail to provide any inform		ete Schedule	A?	Yes	X No
12	! If th	ne answer to line 11 is "Yes," specify the information	on not provided.				

SCHED	ULE A
(Form	5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Zinprojee Zeneme Geeding 710							
Pension Benefit Guaranty Corporation		Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			ion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	19 or fiscal pla	an year beginning 01/01/2019		and en	ding 12/3	1/2019	
A Name of plan				B Three	e-diait		
WELLS FARGO & CO H DEPENDENTS)	IEALTH PLAN	(FOR ELIGIBLE ACTIVE EMP	LOYEES & THEIR		number (PN) •	537
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500		-	-	tion Number	(EIN)
WELLS FARGO & COM	PANY			41-	0449260		
		rning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		OF THE MID-ATLANTIC					
	(c) NAIC	(d) Contract or	(e) Approximate no	umber of		Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
52-0954463	95639	26255	533	533 01/01/201)	12/31/2019
2 Insurance fee and comdescending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, b	orokers, and o	other persons in
(a) Total	amount of com	nmissions paid		(b) To	tal amount o	f fees paid	
		0					0
3 Persons receiving com		fees. (Complete as many entrie					
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	, ,	,				·	
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code
							•

CASE 0:24-cv-03043-LMP-DTS Doc. 39-5 Filed 11/08/24 Page 18 01 /9					
Schedule A (Form 5500)	2019	Page 2 – 1			
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid			
· · ·					
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nar	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid			
(h) Amount of color and trans		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		

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Schedule A (Form 5500) 2019

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with	each carrier may be treated	as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year er		_	
_		racts With Allocated Funds:			
Ū	a	State the basis of premium rates			
	-	Clair the basis of profilmant rates			
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in cor		aujoition or	
		retention of the contract or policy, enter amount.		· OU	
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred	l annuity		
		(3) other (specify)	•		
		(a) The other (specify)			
	£			\ \	
_	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		racts With Unallocated Funds (Do not include portions of these contracts mai			
	а	· / 🗀 · · · · · · · · · · · · · · · · · ·	te participation gua	rantee	
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		>			
		(6)Total additions		7c(6)	
	d ·	Total of balance and additions (add lines 7b and 7c(6)).			
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		L Caron (opcony bolow)			
		•			
		(5) Total deductions		7e(5)	
	f	Polance at the end of the current year (subtract line 7a/5) from line 7d)		7f	

	art I	If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	group of employees of the ng purposes if such contr	acts are expe	erience-rated as a unit	. Where co	ontracts cover individual
8	Bene	efit and contract type (check all applicable boxes)	_				_
	a 🗴	Health (other than dental or vision)	b Dental	c 🗌	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у д П	Supplemental unemp	oloyment	h Prescription drug
	ιĒ	Stop loss (large deductible)	j X HMO contract	k □	PPO contract		I Indemnity contract
	m	Other (specify)	, 🗀	🗀			
	∟	Cities (specify)					
9	Expe	rience-rated contracts:					
Ŭ	•	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium res	The state of the s	9a(3)			
		(4) Earned ((1) + (2) - (3))	<u> </u>			9a(4)	
		Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves		21 (2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes	F	9c(1)(E)			
		(F) Charges for risks or other contingencies					
		(G) Other retention charges				0-(4)(1)	
		(H) Total retention	_			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	<u>—</u>			9c(2)	
	d	Status of policyholder reserves at end of year: (1)	·			9d(1)	
		(2) Claim reserves				9d(2)	
	_	(3) Other reserves				9d(3)	
10		Dividends or retroactive rate refunds due. (Do no nexperience-rated contracts:	ot include amount entered	in line 9c(2).)	9e	
10		Total premiums or subscription charges paid to ca	arrior			10a	2284495
		•				100	2204400
		If the carrier, service, or other organization incurretention of the contract or policy, other than repo				10b	
		cify nature of costs.		s, roport arrio	G110		
_		N Davidson of later and later					
۲	art I	V Provision of Information					
11		the insurance company fail to provide any inform		ete Schedule	A?	Yes	X No
12	lf th	ne answer to line 11 is "Yes," specify the information	on not provided.				

SCHED	U	LE	Α
(Form	5	500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	IIIIIIStration	, , , , , , ,					
Pension Benefit Guaranty Co	orporation	Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2)	inia i dini ia open to i ubile			
For calendar plan year 20	19 or fiscal pla	an year beginning 01/01/2019		and en	ding 12/3	31/2019	
A Name of plan				B Three	e-diait		
WELLS FARGO & CO H DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMPLO	YEES & THEIR		number (PN	N) •	537
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
WELLS FARGO & COM	PANY			41-	0449260		
		rning Insurance Contract A. Individual contracts grouped as					
1 Coverage Information:		-					
(a) Name of insurance ca	ırrier						
KAISER FOUNDATION H	EALTH PLAN	, INC.					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
94-1340523	00000	1915	17436		01/01/201	9	12/31/2019
2 Insurance fee and com descending order of the		nation. Enter the total fees and total	al commissions paid. Li	ist in line 3	the agents,	brokers, and c	other persons in
(a) Total	amount of com	nmissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com		fees. (Complete as many entries					
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
	. ,	<u>, , , , , , , , , , , , , , , , , , , </u>	•				
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code

CASE 0:24-cv-03043-LMP-D1S D0c. 39-5 Filed 11/08/24 Page 22 01 79					
Schedule A (Form 5500)	2019	Page 2 – 1			
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
	me and address of the agent, broke	r, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid			
(I) Assessed of a class with a second		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid			
(II) Assessment of a little		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		

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Schedule A (Form 5500) 2019

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contract	s with each carrier ma	y be treated a	s a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		. 4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		. 5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferre (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	neck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in se	eparate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			. 7d	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		\				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

P	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.						
0	Dan		uai contracts with each ca	amei may be	ireated as a utilit for pr	urposes or i	пів тероп.
8		efit and contract type (check all applicable boxes)	. □ .				⊒ □
	а	Health (other than dental or vision)	b Dental	с 🗌	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k 🗌	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	I	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F) 9c(1)(G)			
		(G) Other retention charges				00/1\/L	A
		(H) Total retention	_			9c(1)(H))
	_1	(2) Dividends or retroactive rate refunds. (These		LI			
	d	Status of policyholder reserves at end of year: (1	•			9d(1)	
		(2) Claim reserves				9d(2)	
	_	(3) Other reserves				9d(3)	
10	e No	Dividends or retroactive rate refunds due. (Do no onexperience-rated contracts:	or include amount entered	in line 90(2).)	9e	
10	a	Total premiums or subscription charges paid to c	arrior			. 10a	100212744
						IVa	100212144
	b Spe	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo ecify nature of costs.				. 10b	
D	art						
						Vas	✓ No
11		d the insurance company fail to provide any inform		ete Schedule	A?	Yes	X No
12	l If t	the answer to line 11 is "Yes," specify the informati	on not provided.				

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Zinprojee Benefite Geeding 716	- In the state of						
Pension Benefit Guaranty Co	orporation		s are required to provide to ERISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	19 or fiscal pla	an year beginning 01/01/2019		and en	ding 12/31	1/2019	
A Name of plan				B Three	e-diait		
WELLS FARGO & CO H DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMP	LOYEES & THEIR		number (PN)) •	537
C Plan sponsor's name a		ne 2a of Form 5500		· ·	yer Identifica	tion Number	(EIN)
WELLS FARGO & COM	PANY			41-	-0449260		
		rning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		NORTHWEST					
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
93-0798039	95540	1310	2923		01/01/2019	1	12/31/2019
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, b	rokers, and o	other persons in
(a) Total	amount of com	nmissions paid		(b) To	otal amount o	f fees paid	
		0					0
3 Persons receiving com		fees. (Complete as many entrie					
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees v	were paid	
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees v	were paid	
						·	
(b) Amount of sales a	nd bass	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
							•

CASE 0:24	4-cv-03043-LMP-DTS	Doc. 39-5	Filed 11/08/24	Page 26 of 79			
Schedule A (Form 5500)	2019		Page 2 – 1				
(a) Nar	ne and address of the agent, broke	er, or other person t	to whom commissions or fe	ees were paid			
		Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose		Organization code		
(a) Nan	ne and address of the agent, broke	er, or other person t	to whom commissions or fe	ees were paid			
(h) Amount of sales and base		Fees and other co	ommissions paid		(e) Organization		
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose		code		
(a) Nan	me and address of the agent, broke	er, or other person t	to whom commissions or fe	ees were paid			
		Fees and other co	ommissions paid		(e)		
(b) Amount of sales and base	(a) Amount	Tees and other co			Organization		
commissions paid	(c) Amount		(d) Purpose		code		
(a) Non	no and address of the agent broke	ur or other person t	to whom commissions or fo	and ware poid			
(a) Ivai	ne and address of the agent, broke	s, or other person	O WHOTH COMMISSIONS OF RE	es were palu			
(b) Amount of sales and base	Fees and other commissions paid						
commissions paid	(c) Amount		(d) Purpose		Organization code		
(a) Nar	me and address of the agent, broke	er, or other person t	to whom commissions or fe	ees were paid			
``	<u> </u>	·					

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

Part II								
		Where individual contracts are provided, the entire group of such indiv	idual contracts	with each carrier may be treated	d as a unit for purposes of			
1	C	this report.		4				
		ent value of plan's interest under this contract in the general account at year						
_		ent value of plan's interest under this contract in separate accounts at year e	nd	5				
6	Cont	racts With Allocated Funds:						
	а	State the basis of premium rates						
	_							
	b	Premiums paid to carrier						
	С	Premiums due but unpaid at the end of the year		6c				
	d	If the carrier, service, or other organization incurred any specific costs in co						
		retention of the contract or policy, enter amount.						
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
		(4)						
	£	If contract numbered in whole or in part to distribute banefits from a termin	ating plan abo	ak bara				
_	1	If contract purchased, in whole or in part, to distribute benefits from a termin						
1	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma						
	а	Type of contract: (1) \square deposit administration (2) \square immedia	ate participation	guarantee				
		(3) guaranteed investment (4) other	•					
	b	Balance at the end of the previous year		7b				
	С	Additions: (1) Contributions deposited during the year	7c(1)	,				
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		•	3 (3)					
				- (2)				
	_	(6)Total additions						
	d	Total of balance and additions (add lines 7b and 7c(6))		7d				
	е	Deductions:						
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(2)					
		(3) Transferred to separate account	7e(3)					
		(4) Other (specify below)	. 7e(4)					
		>						
		(-) -		7-/5				
	,	(5) Total deductions						
	Ť	Ralance at the end of the current year (subtract line 7e/5) from line 7d)		7f				

	art I	If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	group of employees of the ng purposes if such contr	acts are expe	erience-rated as a uni	t. Where co	ontracts cover individual
8	Bene	efit and contract type (check all applicable boxes)	_	_			_
	a 🛚	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у д 🗌	Supplemental unem	ployment	h Prescription drug
	iΓ	Stop loss (large deductible)	j X HMO contract	k□	PPO contract		I Indemnity contract
	m	Other (specify)	, 🗀	Ц			
	L	_ Cities (specify) /					
9	Expe	erience-rated contracts:					
Ŭ	•	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	•				
		(3) Increase (decrease) in unearned premium res	The state of the s	9a(3)			
		(4) Earned ((1) + (2) - (3))	<u> </u>			9a(4)	
		Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves		21 (2)			
		(3) Incurred claims (add (1) and (2))	<u> </u>			. 9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies					
		(G) Other retention charges		9c(1)(G)		T	
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	·			. 9d(1)	
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2) .)	. 9e	
10		nexperience-rated contracts:					
		Total premiums or subscription charges paid to c				. 10a	17600936
		If the carrier, service, or other organization incurr				. 10b	
	Spec	retention of the contract or policy, other than repo cify nature of costs.	nred in Part I, line 2 above	e, report amo	unt	100	
	Opo.	ony material or decide					
Р	art l	V Provision of Information					
11		I the insurance company fail to provide any inform	ation necessary to comple	ete Schedule	А?П	Yes	X No
		the answer to line 11 is "Yes," specify the informati					
. 4		is anomor to line in to 100, specify the illicitiati	cirriot provided.				

SCHED	ULE	A
(Form	5500)	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	IIIIIIISIIalioii	, , , , , , ,		00.			
Pension Benefit Guaranty Co	orporation	Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2)	I III3 I OIII I3 OPEII IO I UDIIC			
For calendar plan year 20	19 or fiscal pla	an year beginning 01/01/2019		and en	ding 12/3	31/2019	
A Name of plan				B Three	e-diait		
WELLS FARGO & CO H DEPENDENTS)	IEALTH PLAN	(FOR ELIGIBLE ACTIVE EMPLO	YEES & THEIR		number (PN	N) •	537
C Plan sponsor's name a	as shown on li	ne 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
WELLS FARGO & COM	PANY			41-	0449260		
		rning Insurance Contract A. Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		, INC.					
	T					Dall'assault	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contrac	t end of	(f)	From	ontract year (g) To
94-1340523	00000	101872	14690	,	01/01/201	9	12/31/2019
2 Insurance fee and com descending order of the		nation. Enter the total fees and total	al commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
		nmissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com		fees. (Complete as many entries					
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd hase	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code

CASE 0:24	1-cv-03043-LMP-DTS	Doc. 39-5	Filed 11/0	08/24	Page 30 of 79)
Schedule A (Form 5500)	2019	Pa	age 2 – 1	7		
(a) Nar	ne and address of the agent, broker	r, or other person to v	whom commis	sions or fe	ees were paid	
		Fees and other com	missions paid			(e)
(b) Amount of sales and base commissions paid	(c) Amount		•	urpose		Organization code
commissions paid				<u> </u>		Code
(a) Nar	ne and address of the agent, broker	r, or other person to v	whom commis	sions or fe	ees were paid	
		Fees and other com	missions paid			(e)
(b) Amount of sales and base commissions paid	(c) Amount			urpose		Organization code
commissions paid				<u> </u>		Code
(a) Nar	ne and address of the agent, broker	r, or other person to v	whom commis	sions or fe	ees were paid	
		Fees and other com	missions paid			(e)
(b) Amount of sales and base commissions paid	(c) Amount			urpose		Organization code
commissions paid				<u> </u>		Code
(a) Nar	ne and address of the agent, broker	r, or other person to v	whom commis	sions or fe	ees were paid	
		Fees and other com	missions paid			(e)
(b) Amount of sales and base commissions paid	(c) Amount			urpose		Organization code
commissions paid				<u> </u>		Code
(a) Nar	ne and address of the agent, broker	r, or other person to v	whom commis	sions or fe	ees were paid	

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

Filed 11/08/24 Page 31 of 79

Schedule A (Form 5500) 2019

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with e	each carrier may be trea	ted as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
		tracts With Allocated Funds:		•	•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with the acc	quisition or 6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
_	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year		-	
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•	. , ,		
				7.70	
		(6)Total additions)
		Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	Deductions:	- (1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total doductions		7e(5	1
	f	(5) Total deductions			<i>)</i>
	1	Dalance at the end of the current year (Subtract line /e(3) from line /d)		/ 1	1

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are exp	erience-rated as a uni	t. Where co	ntracts cover individual
8	Ben	efit and contract type (check all applicable boxes)	<u></u>		_		<u></u>
	a	X Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unem	ployment	h Prescription drug
	ιĪ	Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)	• 🗆		1		·
	L						
9	Expe	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium rese		9a(3)			
		(4) Earned ((1) + (2) - (3))				. 9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions	F	9c(1)(A)			
		(B) Administrative service or other fees	F	9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)			
		(D) Other expenses	-	9c(1)(E)			
		(E) Taxes(F) Charges for risks or other contingencies	F	9c(1)(F)			_
		(G) Other retention charges					
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	_	_			
	d	Status of policyholder reserves at end of year: (1)					
	u	(2) Claim reserves	·			9d(2)	+
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no				9e	
10	No	onexperience-rated contracts:			,	1	
	а	Total premiums or subscription charges paid to ca	arrier			. 10a	65455787
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection wit	th the acquisition or		
		retention of the contract or policy, other than repo	rted in Part I, line 2 above	e, report amo	ount	. 10b	
	Spe	cify nature of costs.					
P	Doubly Dravisian of Information						
	Part IV Provision of Information						
11		d the insurance company fail to provide any informa		ete Schedule	9 A?	Yes	X No
12	: If t	he answer to line 11 is "Yes," specify the information	on not provided.				

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ac	dministration	File as all a	ttacililent to Form 55	00.			
Pension Benefit Guaranty Co	,	pursuant to E	surance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection	
For calendar plan year 20	119 or fiscal pla	n year beginning 01/01/2019		and er	ding 12/3	31/2019	
A Name of plan WELLS FARGO & CO H DEPENDENTS)	IEALTH PLAN	(FOR ELIGIBLE ACTIVE EMPLO	OYEES & THEIR B Three-digit plan number (Pt			۷) 🕨	537
C Plan sponsor's name a		ne 2a of Form 5500	D Employer Identification Number (EIN) 41-0449260				
		rning Insurance Contract A. Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		WASHINGTON					
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a) Approximate number of ersons covered at end of policy or contract year (f)		Policy or From	contract year (g) To
91-0511770	95672	1907200	393			9	12/31/2019
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, and	other persons in
(a) Total	amount of com	'		(b) To	otal amount	of fees paid	
		0					0
3 Persons receiving com		ees. (Complete as many entries and address of the agent, broker,			:		
(b) Amount of sales a		Fee	s and other commission	ns paid		TO Pana	
commissions pa	iid	(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
		•				·	
(b) Amount of sales a	nd base	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
For Domonicade De desette	nn Ant Natio	see the Instructions for Form 5	500			0-1	adula A (Farm FEOO) 2010

CASE 0:24	4-CV-U3U43-LIVIP-DTS	Doc. 39-5 Filed 11/08/24 Page 34 of 79	9					
Schedule A (Form 5500)	2019	Page 2 – 1						
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid						
(G) Hear	The und address of the agent, broke	ar, or other person to whom commissions or rece were paid						
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code					
commissions para			Code					
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid						
			(e)					
(b) Amount of sales and base	424	Fees and other commissions paid						
commissions paid	(c) Amount	(d) Purpose	code					
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid						
(h) Amount of color and have		Fees and other commissions paid	(e)					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code					
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid						
(-)	a.a. aaa	., c. c						
		Fees and other commissions paid	(e)					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
(b) Amount of a least and be		Fees and other commissions paid	(e)					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code					

Doc. 39-5

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Page 35 of 79

Schedule A (Form 5500) 2019

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with	each carrier may be treated	as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year er		_	
_		racts With Allocated Funds:			
Ū	a	State the basis of premium rates			
	-	Clair the basis of profilmant rates			
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in cor		aujoition or	
		retention of the contract or policy, enter amount.		· OU	
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred	l annuity		
		(3) other (specify)	•		
		(a) The other (specify)			
	£			\ \	
_	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		racts With Unallocated Funds (Do not include portions of these contracts mai			
	а	· / 🗀 · · · · · · · · · · · · · · · · · ·	te participation gua	rantee	
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		>			
		(6)Total additions		7c(6)	
	d ·	Total of balance and additions (add lines 7b and 7c(6)).			
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		L Caron (opcony bolow)			
		•			
		(5) Total deductions		7e(5)	
	f	Polance at the end of the current year (subtract line 7a/5) from line 7d)		7f	

_) (! !	Wolfare Panelit Contract Informa	tion								—
٢	art II	I Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reportific employees, the entire group of such individual	group of emping purposes	if such contr	acts are	expe	rience-rated as a uni	t. Where co	ntracts	cover individual	
8	Bene	fit and contract type (check all applicable boxes)									
	a X		b Denta	al		пП	Vision		d∏∟	ife insurance	
		,	브			므					
	e _	Temporary disability (accident and sickness)	_ =	term disabilit	_		Supplemental unem	ployment	- 🗀	Prescription drug	
	i	Stop loss (large deductible)	j X HMO	contract	ŀ	K	PPO contract		I ∐ Ir	ndemnity contract	
	m	Other (specify)									
9	Exper	ience-rated contracts:									
	a P	remiums: (1) Amount received			9a(1)						
	(2) Increase (decrease) in amount due but unpaid			9a(2)						
	,	3) Increase (decrease) in unearned premium res		F	9a(3)						
	(4) Earned ((1) + (2) - (3))						9a(4)			
		Benefit charges (1) Claims paid		Г	9b(1)						
		2) Increase (decrease) in claim reserves		F							
	(3) Incurred claims (add (1) and (2))						9b(3)			
	(4) Claims charged						9b(4)			
		Remainder of premium: (1) Retention charges (or									
		(A) Commissions		´	9c(1)(A	()					
		(B) Administrative service or other fees		Ī	9c(1)(B						
		(C) Other specific acquisition costs			9c(1)(C	_					
		(D) Other expenses		F	9c(1)(D	_					
		(E) Taxes			9c(1)(E						
		(F) Charges for risks or other contingencies		-	9c(1)(F	_					
		(G) Other retention charges		h i	- ///	_					
		(H) Total retention		_				9c(1)(H)			_
		(2) Dividends or retroactive rate refunds. (These		_		_					_
		Status of policyholder reserves at end of year: (1)		11	L						_
		(2) Claim reserves						9d(1)			_
								9d(2)			
		(3) Other reserves Dividends or retroactive rate refunds due. (Do no						90(3) 9e			
10		experience-rated contracts:	include am	iouni entereu	III IIIIe 90	·(2).)	96			_
10		•	orrior					100		18208	62
	_	Total premiums or subscription charges paid to co						10a		10200	02
		f the carrier, service, or other organization incurretention of the contract or policy, other than repo						10b			
	Spec	ify nature of costs.									
_		/ Duradalan of laterance Con									
Р	art I										
11	Did	the insurance company fail to provide any inform	ation necess	ary to comple	ete Sched	dule	A?	Yes	X No		
12	If th	e answer to line 11 is "Yes," specify the information	on not provid	ded.							

SCHED	U	LE	Α
(Form	5	500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

	- In the state of							
Pension Benefit Guaranty Co	orporation		s are required to provide to ERISA section 103(a)(2)		ion	This Fo	m is Open to Public Inspection	
For calendar plan year 20	19 or fiscal pla	an year beginning 01/01/2019		and en	ding 12/3	1/2019		
A Name of plan				B Three	e-diait			
WELLS FARGO & CO H DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMP	LOYEES & THEIR		number (PN) •	537	
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500		-	-	tion Number	(EIN)	
WELLS FARGO & COM	PANY			41-	0449260			
		rning Insurance Contra A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca SIERRA HEALTH & LIFE		COMPANY, INC.						
	(c) NAIC	(d) Contract or	(e) Approximate no	umber of		Policy or c	ontract year	
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To	
94-0734860	71420	H2001	1	1 01/01/2019)	12/31/2019	
2 Insurance fee and comdescending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in line 3	the agents, b	orokers, and o	other persons in	
(a) Total	amount of com	nmissions paid		(b) To	otal amount o	f fees paid		
		0					0	
3 Persons receiving com		fees. (Complete as many entrie						
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales a	nd base	F	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales a	ad bass	F	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code	

CASE 0:24	4-cv-03043-LMP-DTS	Doc. 39-5	Filed 1	1/08/24	Page 38 of 79	9		
Schedule A (Form 5500)	2019		Page 2 –	1				
(a) Nar	me and address of the agent, broke	r, or other person to	o whom comi	missions or f	ees were paid			
		Fees and other co	mmissions pa	aid		(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose				Organization code		
commissions paid						0000		
()))								
(a) Nar	ne and address of the agent, broke	r, or other person to	o whom comi	missions or f	ees were paid			
		Fees and other co	mmissions pa	aid		(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose				Organization code		
•								
(a) Nar	me and address of the agent, broke	r or other person to	o whom com	missions or f	ees were paid			
(a) Ivai	ne and address of the agent, broke	r, or other person to	o whom com	11113310113 01 1	ees were paid			
(h) Amount of calco and base		Fees and other co	mmissions pa	aid		(e)		
(b) Amount of sales and base commissions paid	(c) Amount		(d)) Purpose		Organization code		
(a) Nar	me and address of the agent, broke	r, or other person to	o whom comi	missions or f	ees were paid			
	· · · · · · · · · · · · · · · · · · ·				•			
(b) Amount of sales and base		Fees and other co	mmissions pa	aid		(e) Organization		
commissions paid	(c) Amount		(d)) Purpose		code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

F	Part	II Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contrac	ts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participati	on guarantee		
		(3) guaranteed investment (4) other				
		_				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:	Γ		1 - 0-	
	_		7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		b				
		7				
					_ ,_,	
	_	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

8 Benefit and contract type (check all appliciable boxes) a	P	art	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	group of employees of the ng purposes if such contr	acts are expe	erience-rated as a uni	t. Where co	ontracts cover individual
e Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Prescription drug I Stop loss (large deductible) j HMO contract k PPO contract I Indemnity contract m Other (specify) V Provision of Information 10 Nonexperience-rated contracts: a Premiums: (1) Amount received. 2) Increase (decrease) in amount due but unpaid. (2) Increase (decrease) in unexared premium reserve. 9a(3) 9a(4) (4) Earned ((1) + (2) (3)). 4) Benefit charges (1) Calisms paid. (2) Increase (decrease) in claim reserves. 9b(2) 9b(3) (3) Increase (decrease) in claim reserves. 9b(2) 9b(3) (4) Claims charged (1) Calisms paid. (B) Administrative service or other fees. 9b(1) 9b(3) (B) Administrative service or other fees. 9c(1)(C) Other specific acquisition costs. 9c(1)(C) Other retention. (B) Charges for risks or other contingencies. 9c(1)(C) Other retention. (C) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.). 9c(2) Other serves. 9d(2) 9d(2) (3) Other reserves. 9d(2) 9d(2) (3) Other reserves. 9d(3) 9d(2) (4) Claims reserves. 9d(2) 9d(3) (5) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9c(2) Puidends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9c(3) 9d(3) 9d(3) (4) Claims reserves. 9d(3) 9d(3) 9d(3) (5) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9c(3) Other reserves. 9d(4) 9d(4) (5) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9c(3) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9c(3) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9c(3) Dividends or re	8	Ben	efit and contract type (check all applicable boxes)					
i		а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
i		е	Temporary disability (accident and sickness)	f Long-term disabilit	y g∏	Supplemental unem	ployment	h Prescription drug
Per IV Provision of Information Per IV Provision of Information Part IV Provision of Information Provision of Informatical Provision Provision of Informatical Provision P		ιĖ		- 😾				
9 Experience-rated contracts: a Premiums: (1) Amount received		- L	<u>-</u>	, M Time contract	., □	TT O COMMON		
a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unearend premium reserve. (4) Earned ((1) + (2) - (3)). (5) Benefit charges (1) Citains paid. (6) Increase (decrease) in claim reserves. (7) Increase (decrease) in claim reserves. (8) Increase (decrease) in claim reserves. (9) (2) Increase (decrease) in claim reserves. (8) Increase (decrease) in claim reserves. (9) (2) Increase (decrease) in claim reserves. (9) (2) Increase (decrease) in claim reserves. (9) (4) Claims charged. (A) Commissions. (B) Administrative service or other fees. (B) Administrative service or other fees. (C) Other expenses. (D) Other expenses. (E) Taxes. (E) Taxes. (C) Other expenses. (D) Other expenses. (E) Taxes. (C) Other expenses. (D) Other expenses. (E) Total reserves. (C) Other retention charges. (D) Other retention other created. (D) Other expenses. (D) Other expe			Other (specify) F					
a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unearend premium reserve. (4) Earned ((1) + (2) - (3)). (5) Benefit charges (1) Citains paid. (6) Increase (decrease) in claim reserves. (7) Increase (decrease) in claim reserves. (8) Increase (decrease) in claim reserves. (9) (2) Increase (decrease) in claim reserves. (8) Increase (decrease) in claim reserves. (9) (2) Increase (decrease) in claim reserves. (9) (2) Increase (decrease) in claim reserves. (9) (4) Claims charged. (A) Commissions. (B) Administrative service or other fees. (B) Administrative service or other fees. (C) Other expenses. (D) Other expenses. (E) Taxes. (E) Taxes. (C) Other expenses. (D) Other expenses. (E) Taxes. (C) Other expenses. (D) Other expenses. (E) Total reserves. (C) Other retention charges. (D) Other retention other created. (D) Other expenses. (D) Other expe	9	Evne	prience-rated contracts:					
(2) Increase (decrease) in amount due but uppaid. (3) Increase (decrease) in uneamed premium reserve. (4) Earmed ((f) - (2) - (3)). (5) Benefit charges (1) Claims paid. (6) Earmed ((f) - (2) - (3)). (7) Incurred claims (add (1) and (2)). (8) Administrative service or other fees. (9) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	,			ſ	9a(1)			
(3) Increase (decrease) in unearmed premium reserve (4) Earmed ((1) + (2) - (3))		u	. ,					
(4) Earned ((1) + (2) - (3))								
b Benefit charges (1) Claims paid				-			9a(4)	
(2) Increase (decrease) in claim reserves. (3) Incurred claims (add (1) and (2)) (4) Claims charged. (A) Commissions. (B) Administrative service or other fees. (B) Administrative service or other fees. (C) Other specific acquisition costs (D) Other expenses. (E) Taxes. (F) Charges for risks or other contingencies. (B) Other retention charges. (C) Other specific acquisition costs (D) Other retention charges. (E) Taxes. (B) Set(1)(E) (C) Other specific acquisition costs (B) Other retention. (C) Other specific acquisition costs (D) Other reserves. (E) Taxes. (C) Other specific acquisition costs (D) Other reserves. (E) Taxes. (C) Other specific acquisition costs (D) Other reserves. (E) Taxes. (C) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (D) Other reserves. (E) Other reserves. (D) Other reserves. (E) Other reserves. (D) Other reserves. (E) Other reserves. (D) Other rese		b		The state of the s				
(3) Incurred claims (add (1) and (2)). (4) Claims charged. C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other specific acquisition costs. (E) Taxes. (F) Charges for risks or other contingencies. (F) Charges for risks or other contingencies. (F) Charges for risks or other contingencies. (G) Other retention charges. (F) Charges for risks or other contingencies. (H) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.). (2) Claim reserves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves. (4) Other reserves. (5) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) (6) Nonexperience-rated contracts: (7) Anonexperience-rated contracts: (8) Addisorded or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) (8) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) (9) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) (9) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) (10) Nonexperience-rated contracts: (10) Nonexperience-rated contracts: (10) A 1501 (10) Provision of Information (11) Did the insurance company fall to provide any information necessary to complete Schedule A?				•	21 (2)			
(4) Claims charged. C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other experses. (E) Taxes. (F) Charges for risks or other contingencies. (G) Other retention charges (H) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash. or credited.) (B) Claim reserves. (C) Claim reserves. (B) Other reserves. (C) Claim reserves. (C) Claim reserves. (C) Claim reserves. (C) Claim reserves. (C) Other reserves. (C) Other reserves. (C) Claim reserves. (D) Nonexperience-rated contracts: (E) Taxes.			, ,	L			. 9b(3)	
(A) Commissions 9c(1)(A) 80, Administrative service or other fees 9c(1)(B)								
(B) Administrative service or other fees		С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
(C) Other specific acquisition costs 9c(1)(C) 9c(1)(D) 9c(1)(D) 9c(1)(F) 9c(1)(F) 9c(1)(F)			(A) Commissions		9c(1)(A)			
(D) Other expenses			(B) Administrative service or other fees		9c(1)(B)			
(E) Taxes			(C) Other specific acquisition costs					
(F) Charges for risks or other contingencies			(D) Other expenses					
(G) Other retention charges			` '					
(H) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)								
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)								
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves			,	_	_)
(2) Claim reserves		_						
(3) Other reserves		d		·			_ ` _	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier. 10a 1501 b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 10b Specify nature of costs. Part IV Provision of Information 1 Did the insurance company fail to provide any information necessary to complete Schedule A?								
10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier		_						
a Total premiums or subscription charges paid to carrier	10	_	,	ot include amount entered	in line 9c(2).)	. 9e	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	10	_	·	orrior			100	1501
retention of the contract or policy, other than reported in Part I, line 2 above, report amount							. 10a	1301
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?		D					10h	
11 Did the insurance company fail to provide any information necessary to complete Schedule A?		Spe	cify nature of costs.	ntod ii i ait i, iiilo 2 abov	o, roport amo	unt		
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
	P	Part IV Provision of Information						
12 If the answer to line 11 is "Yes," specify the information not provided.	11	11 Did the insurance company fail to provide any information necessary to complete Schedule A?						
	12	2 If t	ne answer to line 11 is "Yes," specify the informati	on not provided.				

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

Internal Revenue Service Retirement Income Security Act of 1974 (ERISA).				
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 2019 or fiscal pla	n year beginning 01/01/2019		/31/2019	1
A Name of plan WELLS FARGO & CO HEALTH PLAN DEPENDENTS)	N (FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR	B Three-digit plan number (PN)	•	537
C Plan sponsor's name as shown on lir	ne 2a of Form 5500	D Employer Identificat	ion Number	· (FIN)
WELLS FARGO & COMPANY	10 24 01 1 01111 0000		10111140111001	(=114)
WEELSTAIRES & SOMITAIN		41-0449260		
Part I Service Provider Info	ormation (see instructions)			
or more in total compensation (i.e., m plan during the plan year. If a person	dance with the instructions, to report the information oney or anything else of monetary value) in connectic received only eligible indirect compensation for which noting that person when completing the remainder of	n with services rendered to h the plan received the req	the plan or	r the person's position with the
1 Information on Persons Red	ceiving Only Eligible Indirect Compensa	tion		
a Check "Yes" or "No" to indicate wheth	er you are excluding a person from the remainder of	his Part because they rece	ived only e	ligible
	lan 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:		for the serv	rice providers who
(b) Enter nar	ne and EIN or address of person who provided you di	sclosures on eligible indire	ct compens	ation
(b) Enter nar	ne and EIN or address of person who provided you di	sclosures on eligible indire	ct compens	ation
(b) Enter nan	ne and EIN or address of person who provided you di	sclosures on eligible indire	ct compens	ation
. ,	· · · · · · · · · · · · · · · · · · ·			
(h) = :	The second FIN are address of a second FIN are addressed FIN and addressed FIN are addressed FIN are addressed FIN are addressed FIN and addressed FIN are addressed FIN are addressed FIN are addressed FIN and addressed FIN are addressed FIN are addressed FIN and addressed FIN are addressed FIN addressed			-11
(D) Enter nan	ne and EIN or address of person who provided you di	sclosures on eligible indire	ot compens	ation

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Schedule (C (Form 5500) 2019	Page 2- 1
	(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensation
	(b) Fatourage and FIN or address of assess who was ideal was	
	(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	uu disclosures on eligible indirect compensation
	(2)	
	(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensation
	(b) Fatanasan and Fiblios address of	
	(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensation

Schedule C (F	orm 5500) 2019
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Page 3 -	1
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answered	"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 or	r address (see instructions)		
ANTHEM	INSURANCE COMPA	ANIES, INC.				
35-078155	58					
(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	52154792	Yes No X	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
UNITED H	HEALTH CARE					
(b) Service Code(s)	Relationship to employer, employer 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	48615631	Yes No 🛚	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
AETNA						
06-603349	92					
(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	27988001	Yes No X	Yes No		Yes No

	Schedule C	(Form	5500	2019
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answered	l "Yes" to line 1a above	e, complete as many	entries as needed to list ea	ich person receiving, directly or ne plan or their position with the	•	otal compensation
			(a) Enter name and EIN or	address (see instructions)	<u> </u>	<u> </u>
EXPRESS	S SCRIPTS					
43-142056	63					
(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	9235645	Yes No	Yes No No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
DELTA DE	ENTAL	`	- ,			
41-190555	54					
(b) Service Code(s)	Relationship to employer, employer 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
		(a) Enter name and EIN or	address (see instructions)		
CASTLIG	HT HEALTH		-,			
26-198909						
(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 C	(Form	5500	2019
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answered	l "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation sch 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 or	r address (see instructions)		
VSP VISIO	ON CARE					
06-122784	40					
(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	835379	Yes No X	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
HEALTH F	PARTNERS	,	a) Enter hame and Enver	address (see mendensie)		
41-162939	90					
(b) Service Code(s)	Relationship to employer, employer 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	728566	Yes No X	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
KPMG LLI		•	a) Litter hame and Lift of	address (see instructions)		
13-556520						
(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?
10 50	NONE	169680	Yes No X	Yes No		Yes No

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Part I	Service Provider Information (continued)			
or provide questions provider g	ported on line 2 receipt of indirect compensation, other than eligible indirect compensations contract administrator, consulting, custodial, investment advisory, investment manage for (a) each source from whom the service provider received \$1,000 or more in indirect gave you a formula used to determine the indirect compensation instead of an amount ories as needed to report the required information for each source.	ement, broker, or recordkeeping t compensation and (b) each sou	services, answer the following arce for whom the service	
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
	(d) Enter name and EIN (address) of source of indirect compensation		ompensation, including any the service provider's eligibility the indirect compensation.	
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
	(d) Established and EIN (address) of source of individual accompany to	(a) Describe the indirect of		
	(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligib for or the amount of the indirect compensation.		
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect	
	(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.		

Schedule C (Form 5500) 2019

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Part II Service Providers Who Fail or Refuse to F	Provide Infor	mation
		er who failed or refused to provide the information necessary to complete
this Schedule.		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

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Schedule C (Form 5500) 2019

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Pá	art III	Termination Information on Accountants and Enro (complete as many entries as needed)	lled Actuaries (see instructions)
а	Name:		b EIN:
С	Positio		
d	Addres		e Telephone:
	planatior	,	
LA	piariatioi	•	
			Tw.
<u>a</u>	Name:		b EIN:
d	Positio		O Tolonhono.
u	Addres	S.	e Telephone:
Ex	planatior):	
а	Name:		b EIN:
С	Positio	n:	
d	Addres	s:	e Telephone:
Ex	planatior	ı:	
			1.
<u>a</u>	Name:		b EIN:
C	Positio		2711
d	Addres	S:	e Telephone:
Fx	planatior	ŗ.	
	p.aa.o.	•	
а	Name:		b EIN:
c	Positio	n:	— — — — — — — — — — — — — — — — — — —
d	Addres		e Telephone:
Ex	planatior	1:	

SCHEDULE D (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

DFE/Participating Plan Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2019

This Form is Open to Public Inspection.

			mopostion	••
For calendar plan year 2019 or fiscal p	olan year beginning	01/01/2019 a	nd ending 12/31/2019	
A Name of plan			B Three-digit	
WELLS FARGO & CO HEALTH PLAI	N (FOR ELIGIBLE AC	TIVE EMPLOYEES & THEIR	plan number (PN)	537
DEPENDENTS)				
C Plan or DFE sponsor's name as sho	own on line 2a of Form	า 5500	D Employer Identification Number (EIN	1)
WELLS FARGO & COMPANY			41-0449260	
	•	CTs, PSAs, and 103-12 IEs (to be o	ompleted by plans and DFEs)	
		I to report all interests in DFEs)		
a Name of MTIA, CCT, PSA, or 103-	12 IE: WELLS FAR	GO & CO EMPL BENEFIT TRUST		
b Name of sponsor of entity listed in	(a): WELLS FAR	GO & COMPANY		
· · · · · · · · · · · · · · · · · · ·	· ·	T		
C EIN-PN 41-0449260-004	d Entity M	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instruction)		1631
	code	103-12 IE at end of year (see instruc	ions)	
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(0):			
b Name of sponsor of entity listed in	(a).			
C EIN-PN	d Entity	e Dollar value of interest in MTIA, CCT,	PSA, or	
O LINTIN	code	103-12 IE at end of year (see instruct	ions)	
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a):			
- FIN DV	d Entity	e Dollar value of interest in MTIA, CCT,	PSA, or	
C EIN-PN	code	103-12 IE at end of year (see instruct		
a Name of MTIA, CCT, PSA, or 103-	12 IF·			
<u> </u>	·- ·-·			
b Name of sponsor of entity listed in	(a):			
	d Entity	e Dollar value of interest in MTIA, CCT,	DSA or	
C EIN-PN	code	103-12 IE at end of year (see instruction		
2 Name of MTIA CCT DCA or 102	10.15.			
a Name of MTIA, CCT, PSA, or 103-	1216.			
b Name of sponsor of entity listed in	(a):			
		I		
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instruct		
		100 12 12 at one of year (see instruct		
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a).			
Name of sponsor of entity listed in	(a).			
C EIN-PN	d Entity	e Dollar value of interest in MTIA, CCT,		
	code	103-12 IE at end of year (see instruct	ions)	
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
E N C C C C C C C C C C C C C C C C C C	()			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity	e Dollar value of interest in MTIA, CCT,	PSA, or	
C LIN-FIN	code	103-12 IE at end of year (see instruct		

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Schedule D (Form 5500) 2019 Page **2 -** 1 a Name of MTIA, CCT, PSA, or 103-12 IE: **b** Name of sponsor of entity listed in (a): e Dollar value of interest in MTIA, CCT, PSA, or **d** Entity C EIN-PN code 103-12 IE at end of year (see instructions) a Name of MTIA, CCT, PSA, or 103-12 IE: **b** Name of sponsor of entity listed in (a): **d** Entity e Dollar value of interest in MTIA, CCT, PSA, or C EIN-PN code 103-12 IE at end of year (see instructions) a Name of MTIA, CCT, PSA, or 103-12 IE: **b** Name of sponsor of entity listed in (a): **d** Entity e Dollar value of interest in MTIA, CCT, PSA, or C EIN-PN code 103-12 IE at end of year (see instructions) a Name of MTIA, CCT, PSA, or 103-12 IE: **b** Name of sponsor of entity listed in (a): **d** Entity e Dollar value of interest in MTIA, CCT, PSA, or C EIN-PN 103-12 IE at end of year (see instructions) code a Name of MTIA, CCT, PSA, or 103-12 IE: **b** Name of sponsor of entity listed in (a): **d** Entity e Dollar value of interest in MTIA, CCT, PSA, or C EIN-PN 103-12 IE at end of year (see instructions) code a Name of MTIA, CCT, PSA, or 103-12 IE: **b** Name of sponsor of entity listed in (a): **d** Entity e Dollar value of interest in MTIA, CCT, PSA, or C EIN-PN code 103-12 IE at end of year (see instructions) a Name of MTIA, CCT, PSA, or 103-12 IE: **b** Name of sponsor of entity listed in (a): **d** Entity e Dollar value of interest in MTIA, CCT, PSA, or C EIN-PN code 103-12 IE at end of year (see instructions) a Name of MTIA, CCT, PSA, or 103-12 IE: **b** Name of sponsor of entity listed in (a): **d** Entity e Dollar value of interest in MTIA, CCT, PSA, or C EIN-PN 103-12 IE at end of year (see instructions) code a Name of MTIA, CCT, PSA, or 103-12 IE: **b** Name of sponsor of entity listed in (a): **d** Entity e Dollar value of interest in MTIA, CCT, PSA, or C EIN-PN code 103-12 IE at end of year (see instructions) a Name of MTIA, CCT, PSA, or 103-12 IE:

e Dollar value of interest in MTIA, CCT, PSA, or

103-12 IE at end of year (see instructions)

b Name of sponsor of entity listed in (a):

C EIN-PN

d Entity

code

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Schedule D (Form 5500) 2019

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Р	art II	Information on Participating Plans (to be completed by DFEs) (Complete as many entries as needed to report all participating plans)	
а	Plan nam		
b	Name of plan spor	nsor	C EIN-PN
а	Plan nan	ne	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nan	ne	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nam	е	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nam	е	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nam	е	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nam	е	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nam	e	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nan	e e	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nam	е	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nam	е	
b	Name of plan spor	nsor	C EIN-PN
а	Plan nam	е	
b	Name of plan spor	nsor	C EIN-PN

SCHEDULE G (Form 5500)

Department of Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Financial Transaction Schedules

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.

2019

OMB No. 1210-0110

This Form is Open to Public Inspection.

			,	io ao air atta					Inspection.	
For c	For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and er						12/31/2	2019		
	me of plan LS FARGO & CO H	EALTH PLAN (FOR ELIGIB	MPLOYEES 8	PLOYEES & THEIR DEPENDENTS) B Three-digit plan number (PN)			537			
	an sponsor's name a	as shown on line 2a of Form PANY	5500			D	Employer lo 41-044926		ion Number (EIN	N)
Part I Schedule of Loans or Fixed Income Obligations in Default or Classified as Uncollectible Complete as many entries as needed to report all loans or fixed income obligations in default or classified as uncollectible. Check box (a) if obligor is known to be a party in interest. Attach Overdue Loan Explanation for each loan listed. See Instructions.										if obligor
(a)	(b) lde	entity and address of obligo	r		ed description of loan includ and value of collateral, any renegotiation	/ reneg	gotiation of th	ne Ioan a		
		Amount received d	uring reporting	year				Amount	overdue	
(d) (Original amount of loan	(e) Principal	(f) Inte	erest	(g) Unpaid balance at end of year		(h) Principa	I	(i) Intere	est
(a)	(b) lde	entity and address of obligo	r		ed description of loan includ and value of collateral, any renegotiatio	/ reneg		ne Ioan a		
		Amount received d	uring reporting	vear				Amount	overdue	
(d) (Original amount of loan	(e) Principal	(f) Inte	<u> </u>	(g) Unpaid balance at end of year		(h) Principa	I	(i) Intere	est
(a) (b) Identity and address of obligor			(c) Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items							
		Amount received d	uring reporting	year				Amount	overdue	
(d) (Original amount of loan	Amount received d	uring reporting (f) Inte	<u>* </u>	(g) Unpaid balance at end of year		(h) Principa		overdue (i) Intere	est

		ASE 0:24-cv-0304; (Form 5500) 2019	3-LMP-DT	TS Doc. 39-5 Filed 11/08/24 Page 53 of 79				
(a)	(b) Ide	entity and address of obligor		(c) Detailed	ed description of loan includin e of collateral, any renegotiati oth	g dates of making and matu on of the loan and the terms ner material items	urity, interest rate, the type is of the renegotiation, and	
		Amount received du	uring reporting	year		Amount	overdue	
(d)	Original amount of loan	(e) Principal	(f) Inte	rest	(g) Unpaid balance at end of year	(h) Principal	(i) Interest	
(a) (b) Identity and address of obligor					ed description of loan including of collateral, any renegotiation of	g dates of making and mate on of the loan and the terms ner material items	urity, interest rate, the type is of the renegotiation, and	
(-1)	Original and and of	Amount received du	uring reporting	year	(a) Hanneld haloman dead	Amount	overdue	
(a)	Original amount of loan	(e) Principal	(f) Inte	rest	(g) Unpaid balance at end of year	(h) Principal	(i) Interest	
(a) (b) Identity and address of obligor				(c) Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items				
		Amount received du	uring reporting	year Amount overdue				
(d)	Original amount of loan	(e) Principal	(f) Inte	rest	(g) Unpaid balance at end of year	(h) Principal	(i) Interest	
(a)	(b) Ide	entity and address of obligor		(c) Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items				
]							
	Amount received during reporting			year		Amount	overdue	
(d)	Original amount of loan	(e) Principal	(f) Inte	erest	(g) Unpaid balance at end of year	(h) Principal	(i) Interest	
(a)	(b) Ide	entity and address of obligor	,		ed description of loan including of collateral, any renegotiation of			

(g) Unpaid balance at end of year

Amount overdue

(h) Principal

(i) Interest

Amount received during reporting year

(f) Interest

(e) Principal

(d) Original amount of loan

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Schedule G (Form 5500) 2019

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Part II	Complete as m	nany entries as need	ed to re	r Classified as Uncoll port all leases in default or c planation for each lease liste	lassified as uncollectible. C	heck box (a) if lessor or less	see is known to be a		
(a)		of lessor/lessee	(c) Re	elationship to plan, employer, loyee organization, or other party-in-interest	, (d) Terms and descri purchased, term	(d) Terms and description (type of property, location and date it was purchased, terms regarding rent, taxes, insurance, repairs, expenses, renewal options, date property was leased)			
(e) Or	riginal cost	(f) Current value at lease	time of	(g) Gross rental receipts during the plan year	(h) Expenses paid during the plan year	(i) Net receipts	(j) Amount in arrears		
(a)	(b) Identity	of lessor/lessee		elationship to plan, employer, loyee organization, or other party-in-interest	purchased, term	ption (type of property, loca s regarding rent, taxes, insu ewal options, date property	ırance, repairs,		
(e) Or	riginal cost	(f) Current value at lease	time of	(g) Gross rental receipts during the plan year	(h) Expenses paid during the plan year	(i) Net receipts	(j) Amount in arrears		
(a)	(b) Identity	of lessor/lessee		elationship to plan, employer, loyee organization, or other party-in-interest	purchased, term	ption (type of property, loca s regarding rent, taxes, inst ewal options, date property	ırance, repairs,		
(e) Or	riginal cost	(f) Current value at lease	time of	(g) Gross rental receipts during the plan year	(h) Expenses paid during the plan year	(i) Net receipts	(j) Amount in arrears		
(a)	(b) Identity	of lessor/lessee	(c) Relationship to plan, employer, employee organization, or other party-in-interest		purchased, term	(d) Terms and description (type of property, location and date it was purchased, terms regarding rent, taxes, insurance, repairs, expenses, renewal options, date property was leased)			
(e) Or	riginal cost	(f) Current value at lease	time of	(g) Gross rental receipts during the plan year	(h) Expenses paid during the plan year	(i) Net receipts	(j) Amount in arrears		
(a)	(b) Identity	of lessor/lessee		elationship to plan, employer, loyee organization, or other party-in-interest	purchased, term	ption (type of property, loca s regarding rent, taxes, insu ewal options, date property	ırance, repairs,		
(e) Or	riginal cost	(f) Current value at lease	time of	(g) Gross rental receipts during the plan year	(h) Expenses paid during the plan year	(i) Net receipts	(j) Amount in arrears		
(a)	(b) Identity	of lessor/lessee		elationship to plan, employer, loyee organization, or other party-in-interest	purchased, term	ption (type of property, loca s regarding rent, taxes, insu ewal options, date property	ırance, repairs,		
(e) Or	riginal cost	(f) Current value at lease	time of	(g) Gross rental receipts during the plan year	(h) Expenses paid during the plan year	(i) Net receipts	(j) Amount in arrears		

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Schedule G (Form 5500) 2019

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Part III	Complete as many entries as needed to report all nonexempt transactions. Caution: If a nonexempt prohibited transaction occurred with respect to a disqualified person, file Form 5330 with the IRS to pay the excise tax on the transaction.										
(a) Identity	of party involv		(b) Relationship to or other party	plan, employer,	plan, employer, (c) Description of transaction including maturity date,			(d) Purchase price			
WELLS FAF	RGO & COMP	ANY	PLAN SPONSOR			PLAN ASSETS FOR BENEF					
(e) Selli	ng price	(1	f) Lease rental	(g) Transaction	expenses	(h) Cost of asset	(i) Current value of asset	(j) Net gain (or loss) on each transaction			
						623114	662872	39758			
(a) Identity	of party involv	/ed	(b) Relationship to or other party			cription of transaction includ of interest, collateral, par or		(d) Purchase price			
(e) Selli	ng price	(1	f) Lease rental	(g) Transaction	expenses	(h) Cost of asset	(i) Current value of asset	(j) Net gain (or loss) on each transaction			
(a) Identity	of party involv	/ed	(b) Relationship to or other party			cription of transaction includ of interest, collateral, par or		(d) Purchase price			
(e) Selli	ng price	(1	f) Lease rental	(g) Transaction	expenses	(h) Cost of asset	(i) Current value of asset	(j) Net gain (or loss) on each transaction			
			(b) Relationship to	plan, employer.	(c) Des	cription of transaction includ	ing maturity date.				
(a) Identity	of party involv	/ed	or other party			of interest, collateral, par or		(d) Purchase price			
(e) Selli	ng price	(f) Lease rental	(g) Transaction	expenses	(h) Cost of asset	(i) Current value of asset	(j) Net gain (or loss) on each transaction			
(a) Identity	of party involv	/ed	(b) Relationship to or other party		` '	cription of transaction includ of interest, collateral, par or		(d) Purchase price			
(e) Selli	ng price	(1	f) Lease rental	(g) Transaction	expenses	(h) Cost of asset	(i) Current value of asset	(j) Net gain (or loss) on each transaction			
(a) Identity	of party involv	/ed	(b) Relationship to or other party			cription of transaction includ of interest, collateral, par or		(d) Purchase price			
(e) Selli	ng price	(1	f) Lease rental	(g) Transaction	expenses	(h) Cost of asset	(i) Current value of asset	(j) Net gain (or loss) on each transaction			

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 Inspection

Pension Benefit Guaranty Corporation				Inspection	1
For calendar plan year 2019 or fiscal plan	year beginning 01/01/2019	and ending 1	12/31/2019		
A Name of plan		B Thre	ee-digit		
	FOR ELIGIBLE ACTIVE EMPLOYEES & T	HEIR plan	n number (PN)	•	537
DEPENDENTS)					
C Plan sponsor's name as shown on line	e 2a of Form 5500	D Emp	loyer 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
a Total noninterest-bearing cash	1a	3186460	1715918
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 E	mployer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2	2) Employer real property	1d(2)		
е в	uildings and other property used in plan operation	1e		
f To	otal assets (add all amounts in lines 1a through 1e)	1f	31525586	10807549
	Liabilities			
g в	enefit claims payable	1g		
h o	perating payables	1h		
i A	cquisition indebtedness	1i		
j o	ther liabilities	1j		
k To	otal liabilities (add all amounts in lines 1g through1j)	1k	0	0
	Net Assets			
I N	et assets (subtract line 1k from line 1f)	11	31525586	10807549

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
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

Schedule H (Form 5500) 2019

Page 3

			(;	a) Am	ount			(b) T	Γotal	
	(6) Net investment gain (loss) from common/collective trusts	2b(6)								
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)								
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)							2017	505
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)								
	(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)								
С	Other income	2c								
d	Total income. Add all income amounts in column (b) and enter total	2d							2545434	137
	Expenses									
е	Benefit payment and payments to provide benefits:	-					•			
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		2	212149	9963				
	(2) To insurance carriers for the provision of benefits	2e(2)			206693	3488				
	(3) Other	2e(3)								
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)							2418843	451
f	Corrective distributions (see instructions)	2f								
g	Certain deemed distributions of participant loans (see instructions)	2g								
h	Interest expense	2h								
i	Administrative expenses: (1) Professional fees	2i(1)								
	(2) Contract administrator fees	2i(2)			147308	3723				
	(3) Investment advisory and management fees	2i(3)								
	(4) Other	2i(4)								
	(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)							147308	723
j	Total expenses. Add all expense amounts in column (b) and enter total	2j							2566152	174
	Net Income and Reconciliation	-								
k	Net income (loss). Subtract line 2j from line 2d	2k							-20718	037
I	Transfers of assets:									
	(1) To this plan									
	(2) From this plan	2l(2)								
Pa	art III Accountant's Opinion									
3	Complete lines 3a through 3c if the opinion of an independent qualified public attached.	accountant i	s attached to	o this I	Form 5	500. Cor	mplete line (3d if a	ın opinioı	n is not
	The attached opinion of an independent qualified public accountant for this pl	lan is (see ins	structions):							
	(1) Unmodified (2) Qualified (3) X Disclaimer (4)) Adverse	,							
b	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.10	 03-8 and/or 1	03-12(d)?				X Yes		No	
	Enter the name and EIN of the accountant (or accounting firm) below:									
	(1) Name: KPMG LLP		(2) EIN:	: 13-5	565207	7				
d	The opinion of an independent qualified public accountant is not attached be (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached	ecause: ached to the i	next Form 55	ua 00	ırsuant	to 29 CF	FR 2520.104	 4-50.		
Pa	art IV Compliance Questions			•						
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete lines 4j and 4l. MTIAs also do not complete lines 4j and 4l. MTIAs also do		e lines 4a, 4e	e, 4f, 4	lg, 4h, 4	4k, 4m, 4	4n, or 5.			
	During the plan year:	ao iii i o 4 1.		Γ	Yes	No		Amo	ount	
а	Was there a failure to transmit to the plan any participant contributions with	nin the time								
	period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction	prior year fa		4a		X				
b	Were any loans by the plan or fixed income obligations due the plan in defa									
	close of the plan year or classified during the year as uncollectible? Disreg secured by participant's account balance. (Attach Schedule G (Form 5500 checked.)) Part I if "Yes	s" is	4b		Х				

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Schedule H (Form 5500) 2019

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Yes No **Amount** Were any leases to which the plan was a party in default or classified during the year as C uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) Χ 4c Were there any nonexempt transactions with any party-in-interest? (Do not include transactions d reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is Χ 39758 checked.)..... 4d 100000000 Was this plan covered by a fidelity bond?..... X 4e Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by f fraud or dishonesty? 4f Х g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?..... Χ 4g Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?..... Х 4h Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)..... 4i Χ Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)..... Χ 4i Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? Χ 4k Has the plan failed to provide any benefit when due under the plan?..... 41 Χ If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR m Χ 2520.101-3.)..... 4m If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3..... 4n 5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?...... X No If "Yes," enter the amount of any plan assets that reverted to the employer this year If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.) 5b(1) Name of plan(s) 5b(2) EIN(s) 5b(3) PN(s) 5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? Not determined If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year_ (See instructions.)

Financial Statements and Supplemental Schedules (Modified Cash Basis)

December 31, 2019 and 2018

(With Independent Auditors' Report Thereon)



KPMG LLP Suite 1400 55 Second Street San Francisco, CA 94105

Independent Auditors' Report

The Plan Administrator
Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents):

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents), which comprise the statements of net assets available for benefits (Modified Cash Basis) as of December 31, 2019 and 2018, and the related statements of changes in net assets available for benefits (Modified Cash Basis) for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting described in note 2; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the financial statements in the circumstances. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the audits in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the *Basis for Disclaimer of Opinion* paragraph, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in note 3, which was certified by Wells Fargo Bank, N.A., the trustee of the Plan, except for comparing such information with the related information included in the financial statements. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained certifications from the trustee as of and for the years ended December 31, 2019 and 2018, that the information provided to the plan administrator by the trustee is complete and accurate.

Disclaimer of Opinion

Because of the significance of the matter described in the *Basis for Disclaimer of Opinion* paragraph, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion. Accordingly, we do not express an opinion on these financial statements.



Basis of Accounting

We draw attention to note 2 to the financial statements, which describes the basis of accounting. The financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our disclaimer of opinion is not modified with respect to this matter.

Other Matter

The supplemental schedules of Schedule H, line 4i – Schedule of Assets (Held at End of Year) (Modified Cash Basis) as of December 31, 2019 and Schedule G, Part III – Nonexempt Transactions (Modified Cash Basis) for the year ended December 31, 2019 are required by the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and are presented for the purpose of additional analysis and are not a required part of the financial statements. Because of the significance of the matter described in the *Basis for Disclaimer of Opinion* paragraph, we do not express an opinion on these supplemental schedules.

Report on Form and Content in Compliance with DOL Rules and Regulations

The form and content of the information included in the financial statements and supplemental schedules, other than that derived from the information certified by the trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.



September 21, 2020

Statements of Net Assets Available for Benefits (Modified Cash Basis)

December 31, 2019 and 2018

	_	2019	2018
Assets: Plan interest in Master Trust (note 4)	\$	9,091,631	28,339,126
Cash	·	1,715,918	3,186,460
Net assets available for benefits	\$	10,807,549	31,525,586

See accompanying notes to financial statements (modified cash basis).

Statements of Changes in Net Assets Available for Benefits (Modified Cash Basis)

Years ended December 31, 2019 and 2018

	2019	2018
Additions to Plan assets attributed to: Plan interest in Master Trust net investment income	\$ 2,017,505	1,338,403
Contributions: Employer Employee	1,861,261,473 682,155,159	1,906,738,522 692,692,221
Total contributions	2,543,416,632	2,599,430,743
Total additions	2,545,434,137	2,600,769,146
Deductions from Plan assets attributed to: Benefit payments Insurance premiums Administrative expenses	2,212,149,963 206,693,488 147,308,723	2,268,920,887 193,402,030 143,296,163
Total deductions	2,566,152,174	2,605,619,080
Decrease in net assets available for benefits	(20,718,037)	(4,849,934)
Net assets available for benefits: Beginning of year	31,525,586	36,375,520
End of year	\$10,807,549	31,525,586

See accompanying notes to financial statements (modified cash basis).

Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

(1) Description of the Plan

The following description of the Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents) (the Plan) is provided for general information purposes only. Participants should refer to the Plan document for a more complete description of the Plan's provisions. Wells Fargo & Company (Wells Fargo) is the Plan Sponsor. The Plan Administrator is the Director of Human Resources, the Director of Compensation and Benefits and the Head of Enterprise HR Solutions, each of whom, acting individually, may take action as the Plan Administrator.

The Plan was adopted and established effective January 1, 2011 to provide medical, dental, and vision coverage to eligible active employees, their eligible dependents and any related Consolidated Omnibus Budget Reconciliation Act (COBRA) qualified beneficiaries.

Effective July 1, 2017 the Plan was amended to revise the definition of Plan Administrator to include the Head of Enterprise HR Solutions.

(a) General

The Plan is a combination of self-insured and insured health and welfare benefit options that provides for the payment or reimbursement of all or a portion of covered medical, dental and vision expenses incurred by participating active eligible employees (and their participating eligible dependents) of Wells Fargo or participating employers (collectively, the Company). It is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA). Generally, an employee is eligible to participate in the Plan on the first day of the month following one calendar month of service, if he or she qualifies under one of the following employment classifications:

- (i) Regular employees who are regularly scheduled to work 30 hours or more per week.
- (ii) Part-time employees who are regularly scheduled to work between 17½ and 29 hours per week.

Flexible team members are not eligible to enroll or participate in Wells Fargo-sponsored benefit plans. Eligible employees may elect to cover their eligible dependents, also included under the provisions of the Plan, generally defined as the participating employee's spouse, domestic partner, and eligible children. An employee, in addition to their covered dependents, who ceases to be a participant in the Plan may be entitled to elect and pay for any optional extension of benefits provided under COBRA.

(i) Medical Program

The medical program includes medical and prescription drug services through a number of different medical coverage options, including both self-insured and insured medical coverage options as described by the Plan document.

The funding to a certain claims administrator for use of payment of claims is provided each business day via a noninterest bearing account with an imprest cash balance. The cash balance is reflected on the statements of net assets available for benefits.

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Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

Participants enrolled in a high deductible health plan option may establish a tax-advantaged savings vehicle known as a Health Savings Account (HSA) to pay for qualified medical expenses that they or their eligible dependents incur. Contributions to the HSA may be made by the participant or Wells Fargo. The HSA is owned by the participant and is not part of the Plan. Contributions to HSAs and payments of qualified medical expenses from HSAs are not included in the statements of changes in net assets available for benefits.

Prior to January 1, 2019, participants enrolled in a health reimbursement account (HRA) plan option could receive an allocation from Wells Fargo to a HRA. Participants can receive additional allocations by participating in certain health and wellness activities. Participants may use their HRA to pay for qualified medical expenses incurred during the plan year. The HRA is a notional account and no specific funds are set aside or otherwise segregated. Amounts allocated to the HRA are not vested and are subject to forfeiture upon coverage termination. Any amounts remaining at the end of the year can generally be carried over to the next year if the participant remains enrolled in an HRA plan option. The notional amount allocated to participant accounts at December 31, 2019 and 2018 was approximately \$90.4 million and \$109.5 million respectively.

(ii) Dental Program

The dental program offers preventative, restorative, and prosthetic care on a self-insured basis as described in the Plan document. The claims administrator for the dental program has contractual agreements with dentists nationwide. The maximum expense considered for benefits for services received from a participating dentist is the agreed-upon allowable charge between the claims administrator and the participating dentist. The maximum expense for services received from an out-of-network dentist is based on the claim administrator's table of allowances. Participants are responsible for paying the amount in excess of the fee in the table of allowances.

(iii) Vision Program

The vision program provides for the payment or reimbursement of all or a portion of covered expenses for eye examinations and eyeglass frames, lenses, and contacts on a self-insured basis. Benefits differ if participants choose a network provider rather than an out-of-network provider. Each covered participant must generally pay a copayment or coinsurance for each type of covered service provided.

(b) Contributions

Participating employees contribute a set amount throughout the Plan year generally via bi-weekly payroll deductions. The Company contributes at a rate that, together with the employee contributions, is sufficient to pay expected claims, premiums, and administrative expenses. The contribution rate is based on the level of coverage and Plan experience and may change in future Plan years.

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(Continued)

Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

(c) Benefit Payments

The Plan provides benefit payments to or on behalf of eligible participating employees and their eligible dependents for covered medical, dental and vision expenses, as applicable.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The Plan's policy is to prepare its financial statements on a modified cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America. Under such modified cash basis, financial statements are prepared on the basis of cash receipts and disbursements, except that investments are reported at fair value. Consequently, certain revenues are recognized when received rather than when earned and certain expenses are recognized when paid rather than when the obligations are incurred. Accordingly, the accompanying financial statements are not intended to be a presentation in conformity with accounting principles generally accepted in the United States of America.

(b) Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, benefit obligations and changes therein, claims incurred but not reported, claims payable, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

(c) Trust Funds Held by Trustee

The Wells Fargo & Company Employee Benefit Trust (Master Trust) is used to fund benefits under the Plan. Wells Fargo Bank, N.A. (the Trustee), a participating employer in the Plan, is the Trustee of the Master Trust. The Trustee executes purchases and sales of investments in the Master Trust pursuant to the direction of the Employee Benefit Review Committee or its agent. The investments of the Master Trust and changes therein have been reported to the Plan by the Trustee.

(d) Investment Valuation and Income Recognition

The investment in the Master Trust is carried at the current unit value based upon the fair values of the individual investments held by the Master Trust as determined by the Trustee. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis.

(e) Risks and Uncertainties

The Plan may invest in various types of investment securities. Investment securities are exposed to various risks, such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and such changes could materially affect the amount reported in the statements of net assets available for benefits.

7 (Continued)

Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

Plan contributions are made and the actuarial present value of accumulated plan benefits are reported based on certain assumptions pertaining to interest rates, inflation rates, and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

(f) Expenses

Certain Plan administrative expenses such as claims processing, audit and tax preparation fees are paid by the Plan. All fees paid to the Trustee are paid by the Company.

(g) Benefit Payments

Benefit payments are recorded when paid.

(h) New Accounting Pronouncements

In August 2018, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (Update) 2018-13, Fair Value Measurement (Topic 820) Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement. The Update modifies fair value disclosure requirements by removing, modifying or adding to the required fair value disclosures. The Update is effective for fiscal years beginning after December 15, 2019. Early adoption is permitted upon issuance of the Update; allowing an entity to early adopt any removed or modified disclosures upon issuance of the Update and delay adoption of the additional disclosures until their effective date. The Update will not affect the statement of net assets available for benefits or the statement of changes in net assets available for benefits as it only amends the disclosure requirements for fair value disclosures.

(3) Information Certified by Trustee

The Plan Administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, as permitted under such election, the Plan Administrator has obtained certifications as of and for the years ended December 31, 2019 and 2018, from the Trustee that all investment information provided by the Trustee is complete and accurate. Investment information included in the accompanying financial statements and notes to the financial statements as to the investment assets held in the Master Trust managed by the Trustee, and investment income and all investment information in the supplemental schedule is presented in reliance solely upon those certifications.

(4) Plan Interest in Master Trust

The Plan, together with the Wells Fargo & Company Retiree Plan, invests its assets on a commingled basis in the Master Trust. Each participating plan has an undivided interest in the assets of the Master Trust. The fair value of the Plan's interest in the Master Trust is based on the beginning of year value of the Plan's interest in the Master Trust, plus actual employee contributions and allocated employer contributions to the Plan, plus Master Trust investment income allocated to the Plan, less actual distributions and expenses of the Plan. The Plan's interest in the net assets of the Master Trust at December 31, 2019 and 2018 was

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Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

approximately 64% and 87%, respectively. Investment income and employer contributions are allocated to the individual plans based upon the ratio of annual distributions and benefit expenses by each plan.

The following tables present the net assets, including investments, of the Master Trust and the Plan's interest in the Master Trust net assets at December 31, 2019 and 2018:

		2019			
	-	Master Trust Balances	Plan's Interest in Master Trust Balances		
Investments at fair value:	Φ.	1.4.051.010	0.007.600		
Registered investment companies Accrued income	\$	14,051,010 131,036	9,007,629 84,002		
Net assets	\$	14,182,046	9,091,631		
	_	20	018		
		Master Trust Balances	Plan's Interest in Master Trust Balances		
Investments at fair value:		Master Trust	Plan's Interest in Master		
Investments at fair value: Registered investment companies Accrued income	\$	Master Trust	Plan's Interest in Master		

The net investment income of the Master Trust for the years ended December 31, 2019 and 2018 is presented below:

	_	2019	2018
Investment income:			
Interest	\$	1,971,190	1,338,936
Other income		46,045	
Net appreciation in fair value of investments		1,070	219
Total investment income	\$	2,018,305	1,339,155

In accordance with the topic of the *Fair Value Measurements and Disclosures*, FASB Codification, assets and liabilities are measured at fair value in three levels based on the markets in which the assets and liabilities are traded and the reliability of the assumptions used to determine fair value. These levels are:

Level 1 – Valuation is based upon quoted prices for identical assets traded in active markets.

Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

Level 2 – Valuation is based upon quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market.

Level 3 – Valuation is generated from model-based techniques that use significant assumptions not observable in the market. These unobservable assumptions reflect estimates of assumptions that market participants would use in pricing the asset or liability. Valuation techniques may include use of option pricing models, discounted cash flow models and similar techniques.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The following is a description of the valuation methodologies used by the Master Trust to measure investments at fair value. There have been no changes in the methodologies used at December 31, 2019 and 2018.

Investments in *registered investment companies* are valued at fair value based upon quoted prices in an active market of the underlying investments.

The following table sets forth by level, within the fair value hierarchy, the investments of the Master Trust at fair value as of December 31, 2019 and 2018, respectively:

			Decembe	1 01, 101/	
	-	Level 1	Level 2	Level 3	Total
Registered investment companies	\$_	14,051,010			14,051,010
Total investments at fair value	\$_	14,051,010			14,051,010
	_		Decembe	r 31, 2018	
		Level 1	Level 2	Level 3	Total
Registered investment companies	\$	32,528,837			32,528,837

32,528,837

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Total investments at fair value

(Continued)

32,528,837

December 31, 2019

Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

(5) Related-Party Transactions

The Plan engages in transactions (including the transactions in the Master Trust) involving the acquisition or disposition of shares of registered investment companies managed by the Company and the Trustee, which are parties-in-interest with respect to the Plan. These transactions are covered by an exemption from the "prohibited transactions" provisions of ERISA and the Internal Revenue Code (IRC).

(6) Benefit Obligations

(a) Postemployment Benefit Obligation

The postemployment benefit obligation represents the total actuarial present values of all estimated future benefits that are expected to be paid to those employees or former employees who are currently receiving disability benefits, on COBRA continuation or on Parental leave, reduced by the actuarial present value of contributions expected to be received in the future from current plan participants. The actuarial present values of the expected postemployment benefit obligations are determined by discounting the expected future payment stream for each individual currently receiving disability benefits, taking into account probabilities of death, recovery and increases in future medical costs. Expected annual future medical costs are based on historical per capita medical claims, adjusted to reflect current medical cost trends.

For measurement purposes, the following actuarial assumptions were utilized as of December 31:

2019		2018
Discount rate -		
Longterm disability	1.90%	3.00%
Termination from disability	2012 Group long-term disability table	2012 Group long-term disability table
Healthcare cost trend rate	7.10% decreasing 0.30% to 0.40% each year to 4.50% in 2028	7.60% decreasing 0.40% to 0.50% each year to 4.50% in 2026
Average participant contributions for medical coverage	25% of medical costs	25% of medical costs
Service cost	One-year term cost reduced by employer incurred costs	One-year term cost reduced by employer incurred costs

11 (Continued)

Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

The postemployment benefit obligation also includes a component for employees enrolled in a HRA plan option who may move into postemployment status and receive disability benefits (Postemployment HRA-Balance program).

For measurement purposes, the following actuarial assumptions were utilized for measurement of the Postemployment HRA-Balance liability as of December 31:

	2019			018			
Discount rate - HRA	2.55%	3.	3.80%				
HRA benefit obligation	\$ 8,876,000	\$	10,900,000				
Projected post-decrement HRA balance	\$ 1,100	\$	1,150				
Mortality rates healthy and disabled	Pri-2012 mortality study projecte generationally from 2012 with Scale MP-2019						
Retirement rates	Range of 5% to 100% from age	Range of 5% to 100% from age 50 to age 80					
Withdrawal rates	50 to age 80 ithdrawal rates 13% to 45% for ages 25 and less to age 65			13% to 45% for ages 25 and less to age 65			
	provides additional information bligation as of December 31:	n regard	ing the Plan	's accumulated			
Parental Leave or Other	participants on LTD, STD, er Leave of Absence, COBRA oyees in Postemployment	<u> </u>	2019 3,339,000	70,140,000			
That Bulance program		ψ /.	,,557,000	70,140,000			

12 (Continued)

Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

The following provides additional information regarding the Plan's changes in the accumulated postemployment benefit obligation for the year ended December 31:

	_	2019	2018
Balance at beginning of year	\$	70,140,000	65,669,000
Increase (decrease) during the year attributed to:			
Benefits earned		55,607,000	58,041,000
Benefits paid		(51,919,000)	(52,451,000)
Interest		1,327,000	1,301,000
Changes in actuarial assumptions*		64,000	114,000
Actuarial experience and other gains and losses	_	(1,880,000)	(2,534,000)
Balance at end of year	\$_	73,339,000	70,140,000

^{*} In 2019, changes in actuarial assumption from January 1, 2019 to December 31, 2019 include the decrease of the discount rate for long term disability from 3.00% to 1.90%, the change in the long term disability healthcare cost trend rate from 7.60% graded to 4.50% in 2026 to 7.10% graded to 4.50% in 2028 and the decrease in the projected post-decrement HRA balance from \$1,150 to \$1,100.

In 2018, changes in actuarial assumption from January 1, 2018 to December 31, 2018 include the increase of the discount rate for long term disability from 2.10% to 3.00%, the decrease in the healthcare cost trend rate from 8.00% to 7.60% and the increase in the projected post-decrement HRA balance from \$1,100 to \$1,150.

(b) Other Obligations

Due to the Plan's modified cash basis of accounting, certain claims relating to the years ended December 31, 2019 and 2018 were not accrued as of December 31, 2019 and 2018. Net Claims (receivable) payable as of December 31, 2019 and 2018 were approximately \$(43,560,000) and \$43,867,000 respectively. Claims incurred but not reported as of December 31, 2019 and 2018 were approximately \$230,289,000 and \$194,371,000 respectively. Estimated claims incurred but not reported are estimates, which are based on claim run-off experience and are subject to uncertainty.

The Plan's deficiency of net assets available for benefits over the benefit obligation relates to claims incurred but not reported and the projected benefit obligations as of December 31, 2019 and 2018. The funding of the deficiency will be provided by future employer contributions.

Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

(7) Tax Status

The Master Trust established under the Plan to hold the Plan's assets is qualified pursuant to Section 501(c)(9) of the IRC, and, accordingly, the Master Trust's net investment income is ordinarily exempt from income taxes. The Master Trust has obtained a favorable tax determination letter dated February 27, 1979 from the Internal Revenue Service, and the Plan Sponsor believes that the Master Trust, as amended, continues to qualify and to operate in accordance with applicable provisions of the IRC.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the organization has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The Plan Administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2019 and 2018, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan Administrator believes it is not subject to income tax examinations prior to 2016.

(8) Plan Termination

The Company has voluntarily agreed to make contributions to the Plan. Although the Company has not expressed any intention to do so, the Plan Sponsor has the right under the Plan to modify the benefits provided, to discontinue its contributions at any time, and to terminate the Plan subject to the provisions set forth in ERISA. In the event of termination, assets held by the Master Trust will be used to provide for benefits payable as of the date of such termination and for payment of expenses of the Plan, including expenses of termination. Any assets remaining after such benefits and expenses will be distributed in accordance with the requirements of Section 501(c)(9) of the IRC and the regulations thereunder. If the Plan is terminated, the termination shall not affect the rights of any participant to claim benefits that are payable prior to such termination.

(9) Nonexempt Prohibited Transactions

In September 2020, Plan management upon review determined that the Plan Sponsor incurred certain Plan administrative expenses that were later reimbursed by the Plan's Pharmacy Benefit Manager (PBM) vendor in 2019. The PBM vendor's administrative expenses were paid from the Master Trust, thus the reimbursements made by the Plan's PBM vendor to the Plan Sponsor are likely to be deemed to be attributable to Plan assets. In most cases a plan sponsor can advance payment for plan administrative expenses and seek reimbursement from the plan provided that the requirements of Prohibited Transaction Exemption (PTE) 80-26 are satisfied. In the present case, certain reimbursed Plan administrative expenses do not meet the requirements of (PTE) 80-26.

In one case, the administrative expenses that were reimbursed were properly substantiated, but the reimbursement to the Plan Sponsor did not qualify for relief under PTE 80-26 because the reimbursement by the Plan was beyond the 60 day period allowed by PTE 80-26 without a written loan agreement. In other cases, the reimbursements to the Plan Sponsor likely did not qualify for the relief under PTE 80-26 because there was inadequate substantiation as to the nature of the third-party expense for purposes of Section IV(b)

Notes to Financial Statements (Modified Cash Basis)

December 31, 2019 and 2018

of PTE 80-26. In both cases, this resulted in a nonexempt use of plan assets for the benefit of a party-in-interest. In all cases, the Plan Sponsor is repaying both the amounts reimbursed to it by the PBM and an allocable amount of interest as calculated using the DOL interest calculator from the date of reimbursement to the Plan Sponsor until repayment.

On October 1, 2020, the Company plans to reimburse the Master Trust the principal amount of the reimbursed expenses in the amount of \$623,114 plus lost interest of \$39,758 allocable to such amounts.

(10) Subsequent Events

The Plan has evaluated subsequent events from the statement of net assets available for benefits date through September 21, 2020, the date on which the financial statements were available to be issued, and except as noted in note 9 and below, has determined that there are no subsequent events that require adjustment or disclosure.

The spread of COVID-19 around the world in the first quarter of 2020 has caused significant volatility in the U.S. and abroad. There is significant uncertainty around the breadth and duration of business disruptions and health impact related to COVID-19, as well as the impact to the Plan's volume of future benefit claims.

SUPPLEMENTAL SCHEDULES

Schedule 1

WELLS FARGO & COMPANY HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES AND THEIR DEPENDENTS)

Schedule H, Line 4i – Schedule of Assets (Held at End of Year) (Modified Cash Basis)

December 31, 2019

(a)	(b) Identity of issuer, borrower, lessor, or similar party	(c) Description of investment	(d) Number of units		(e) Cost	(f) Current value
	Plan interest in Master Trust	n/a	n/a	\$_	n/a	9,091,631
				\$		9,091,631

See accompanying independent auditors' report.

Schedule 2

WELLS FARGO & COMPANY HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES AND THEIR DEPENDENTS)

Schedule G, Part III - Nonexempt Transactions (Modified Cash Basis)

Year Ended December 31, 2019

	(b)								
	Relationship to							(i)	(j)
(a)	plan,employer	(c)	(d)	(e)	(f)	(g)	(h)	Current	Net gain or
	or other	Description	Purchase	Selling	Lease	Transaction	Cost of	value of	(loss) on each
Identity of party involved	party-in-interest	of Transactions	price	price	rental	expenses	asset	asset	transaction
		Use of Plan assets for							
Wells Fargo & Company	Plan Sponsor	benefit of party-in-interest	\$ —	_	_	_	623,114	662,872	39,758

See accompanying independent auditors' report.

Schedule 1

WELLS FARGO & COMPANY HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES AND THEIR DEPENDENTS)

Schedule H, Line 4i – Schedule of Assets (Held at End of Year) (Modified Cash Basis)

December 31, 2019

(a)	(b) Identity of issuer, borrower, lessor, or similar party	(c) Description of investment	(d) Number of units	(e) Cost	(f) Current value
	Plan interest in Master Trust	n/a	n/a	\$ n/a	9,091,631
				\$ 	9,091,631

See accompanying independent auditors' report.

EXHIBIT 6

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

SIGN

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	Annual Report Id	entification Information								
		al plan year beginning 01/01/2022	and ending 12/31/2022	and ending 12/31/2022						
A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking participating employer information in accordance)										
		X a single-employer plan	a DFE (specify)			,				
B This return/report is:		the first return/report	the final return/report							
		an amended return/report	a short plan year return/report (less than 12 months)							
C If the plan is a collectively-bargained plan, check here										
D Check	box if filing under:	X Form 5558	automatic extension	th	e DFVC program					
		special extension (enter description	n)							
E If this is	s a retroactively adopted	plan permitted by SECURE Act section 2	201, check here	7						
Part II	Basic Plan Inforn	nation—enter all requested information	1							
1a Name		1b	Three-digit plan number (PN) ▶	537						
WELLS	FARGO & CO HEALTH F	1c Effective date of plan 01/01/2011								
2a Plan s Mailin City o	2b Employer Identification Number (EIN) 41-0449260									
WELLS FARGO & COMPANY					2c Plan Sponsor's telephone number 877-479-3557					
MAC A01 420 MON SAN FRA	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.										
	, 40 110		, , , , , , , , , , , , , , , , , , , ,		,,	1				

10/02/2023

10/02/2023

Date

Date

Date

DREW WINELAND

LEE KEEL

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

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

Filed with authorized/valid electronic signature.

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Signature of DFE

Signature of plan administrator

Form 5500 (2022)

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	Form 5500 (2022)	Page 2								
3a	Plan administrator's name and address Same as Plan Sponsor			3b Administrator's EIN 41-0449260						
WELLS FARGO & COMPANY DREW WINELAND MAC N9310-110 550 S. 4TH STREET MINNEAPOLIS, MN 55415					3c Administrator's telephone number 877-479-3557					
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin	4b EIN								
a c	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name Plan Name	4d PN								
5	Total number of participants at the beginning of the plan year			5	188798					
6	Number of participants as of the end of the plan year unless otherwise states 6a(2), 6b, 6c, and 6d).	olete only lines 6a(1),	3							
a(1) Total number of active participants at the beginning of the plan year			6a(1)	186090					
a(2) Total number of active participants at the end of the plan year		6a(2)	173224						
b	Retired or separated participants receiving benefits		6b	2788						
С	Other retired or separated participants entitled to future benefits	6c	0							
d	Subtotal. Add lines 6a(2), 6b, and 6c	6d	176012							
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	6e								
f	Total. Add lines 6d and 6e .	6f								
g	Number of participants with account balances as of the end of the plan year complete this item)	6g								
h	Number of participants who terminated employment during the plan year with less than 100% vested	6h								
7	Enter the total number of employers obligated to contribute to the plan (only	7								
b	 If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4D 4E 									
9a	Plan funding arrangement (check all that apply) (1)	(1) × (2) × (3) × (4) ×	rrangement (check all tha Insurance Code section 412(e)(3) in Trust General assets of the sp	s) insurance contracts						
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where i	ndicated, enter the numb	er attached	d. (See instructions)					
a	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	b General Scho (1) X (2) (3) X (4) X	H (Financial Information)I (Financial Information – Small Plan)							
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) X (6)	D (DFE/ParticipatingG (Financial Trans	_						

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Receipt Confirmation Code

SCHEDULE	Α
(Form 5500))

Insurance 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

Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Co	rporation		ce companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Fo	rm is Open to Public Inspection
For calendar plan year 202	22 or fiscal pla	an year beginning 01/01/2022		and en	nding 12/3	31/2022	
A Name of plan WELLS FARGO & CO HE DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMPL	LOYEES & THEIR		e-digit number (Pl	N) •	537
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		D Emplo	ver Identific	ation Number	(FIN)
WELLS FARGO & COMP		10 24 011 01111 0000		-	0449260	ation Nambor	(====)
Part I Informat on a separa	ion Conce ate Schedule	rning Insurance Contract A. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con	nmission ported on a	S Provide info single Schedu	rmation for each contract le A.
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION PL		RGIA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			•	ontract year
(8) 2.114	code	identification number	policy or contract		(f)	From	(g) To
58-1592076	96237	10371	683		01/01/202	2	12/31/2022
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total a	amount of con	nmissions paid		(b) To	otal amount	of fees paid	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar			ees and other commissio				
commissions pai	d	(c) Amount		(d) Purpose			(e) Organization code
						.,	•
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	<u> </u>	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code

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Schedule A (Form 5500) 2	2022	Page 2 – 1		
	me and address of the agent, broker	, or other person to whom commiss	sions or fees were paid	
	<u> </u>	,	•	
(In) Assessed of color and become		Fees and other commissions paid		(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Pt	urpose	Organization code
(a) Nai	me and address of the agent, broker	, or other person to whom commiss	sions or fees were paid	
		Fees and other commissions paid		(e)
(b) Amount of sales and base	(c) Amount		urpose	Organization
commissions paid	(c) Amount	(u) i	110000	code
(a) Na	me and address of the agent, broker	, or other person to whom commiss	sions or fees were paid	
		Fees and other commissions paid		T
(b) Amount of sales and base			(e) Organization	
commissions paid	(c) Amount	(d) Po	urpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom commiss	sions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Po	urpose	code
(a) Na	me and address of the agent, broker	or other person to whom commiss	sions or fees were naid	
(a) Nai	The and address of the agent, broker	, or other person to whom commis.	sions of fees were paid	
		Fees and other commissions paid		(e)
(b) Amount of sales and base commissions paid	(c) Amount		urpose	Organization code
commissions paid		, ,		5540
				Ì

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Schedule A (Form 5500) 2022

Page 3

ı	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contracts with each carrier may	/ be treated a	s a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5		ent value of plan's interest under this contract in separate accounts at year er		5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity		
		(e) Grant (openity)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)	1.0	
	•	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•	13(3)		
				- (5)	
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	е	Deductions:	= (1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		>			
		(C) Tabel de deseller		70/F)	0

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

Page **4**

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
1 1 2 2 2 2 2 2	
8 Benefit and contract type (check all applicable boxes)	
a X Health (other than dental or vision) b Dental c Vision d Life insurance	е
e Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Prescription	drua
i ☐ Stop loss (large deductible) j ☒ HMO contract k ☐ PPO contract l ☐ Indemnity co	•
	iliaci
m ☐ Other (specify) ▶ 9 Experience-rated contracts:	
a Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	0
b Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2))	0
(4) Claims charged	
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	
(E) Taxes	
(F) Charges for risks or other contingencies	
(G) Other retention charges	
(H) Total retention	0
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	
(2) Claim reserves	
(3) Other reserves	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	
10 Nonexperience-rated contracts:	
Total premiums or subscription charges paid to carrier	3452650
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	
Part IV Provision of Information	
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?	

SCHEDULE A	
(Form 5500)	

Insurance 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

Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Co	rporation		s are required to provide to ERISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	22 or fiscal pl	an year beginning 01/01/2022		and en	ding 12/3	1/2022	
A Name of plan WELLS FARGO & CO HI DEPENDENTS)	EALTH PLAN	I (FOR ELIGIBLE ACTIVE EMPI	LOYEES & THEIR		e-digit number (PN	N) •	537
C Plan sponsor's name a	s shown on I	ine 2a of Form 5500		D Emplo	ver Identific	ation Number	(FIN)
WELLS FARGO & COMP				-	0449260		(=)
		erning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		OF HAWAII					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	ontract year
(b) EIN	code	identification number	policy or contract		(f)	From	(g) To
94-1340523	60053	35612	133		01/01/2022	2	12/31/2022
2 Insurance fee and com- descending order of the		mation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and c	ther persons in
(a) Total a	amount of cor	mmissions paid		(b) To	tal amount	of fees paid	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar			ees and other commissio				<u> </u>
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code

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Scriedule A (Form 5500) 2	2022	Page Z =	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(5)		,	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid	()		code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(h) Amount of colon and have		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) No.	me and address of the agent broken	r, or other person to whom commissions or fees were paid	
(a) Nai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) / uno uno	(L) Lapes	code
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
			1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent broker	r, or other person to whom commissions or fees were paid	•
(a) Nai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(O) / WINSON	(4) (4)	code

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Schedule A (Form 5500) 2022

Page **3**

	_				
F	Part l	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with eac	ch carrier may be treated as a unit fo	or purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Conti	racts With Allocated Funds:		·	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferre (3) ☐ other (specify) ▶	d annuity		
		If contract purchased, in whole or in part, to distribute benefits from a termin	• .) [
7	Conti	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	Type of contract: (1) deposit administration (2) mmedia (3) guaranteed investment (4) other	ate participation guaran	lee	
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account			
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d ⁻	Total of balance and additions (add lines 7b and 7c(6))		7d	0
	e i	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0

Page **4**

Pá	art III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employees of th	racts are exp	perience-rated as a un	it. Where co	ntracts cover individual
8	Benefit a	nd contract type (check all applicable boxes)					
	а 🛚 Не	ealth (other than dental or vision)	b Dental	С	Vision		d Life insurance
	e	emporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	plovment	h Prescription drug
	. =	, , , , , , , , , , , , , , , , , , , ,	j X HMO contract	• -	PPO contract	ipioyinoni	I Indemnity contract
		op loss (large deductible)	nivio contract	n [_ FFO contract		
	m ∐ O	ther (specify)					
9 E	Experience	ce-rated contracts:					
	a Prem	niums: (1) Amount received		9a(1)			
	(2) lı	ncrease (decrease) in amount due but unpai	d	9a(2)			
		ncrease (decrease) in unearned premium re		9a(3)			
	(4) E	Earned ((1) + (2) - (3))				. 9a(4)	0
	b Ben	efit charges (1) Claims paid		9b(1)			
	(2) lı	ncrease (decrease) in claim reserves		9b(2)			
	(3) lı	ncurred claims (add (1) and (2))				9b(3)	0
	(4) (Claims charged				9b(4)	
	C Ren	nainder of premium: (1) Retention charges (on an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	0
		` / Dividends or retroactive rate refunds. (These	_				
		tus of policyholder reserves at end of year: (•	9d(1)	
		Claim reserves				9d(2)	
	. ,	Other reserves				9d(3)	
	` '	dends or retroactive rate refunds due. (Do n				90(3) 9e	
10		perience-rated contracts:	ot ilicidde amount entere	a iii iiiie 30(2	<u>J.)</u>	36	
10			parriar			10a	075474
		al premiums or subscription charges paid to				IUa	875471
	rete	e carrier, service, or other organization incurention of the contract or policy, other than repnature of costs.				10b	
Pa	art IV	Provision of Information				l	
11	Did the	insurance company fail to provide any inform	nation necessary to comp	lete Schedule	e A?	Yes	X No
12	If the ar	nswer to line 11 is "Yes," specify the informat	ion not provided.				

SCHEDULE A
(Form 5500)

Insurance 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

Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Con	poration		es are required to provide the information o ERISA section 103(a)(2).			This Fo	rm is Open to Public Inspection
For calendar plan year 202	22 or fiscal pla	an year beginning 01/01/2022		and en	ding 12/3	31/2022	_
A Name of plan WELLS FARGO & CO HE DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMPI	LOYEES & THEIR		e-digit number (Pl	N) •	537
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		D Emplo	ver Identific	ation Number	(FIN)
WELLS FARGO & COMP		20 011 0111 0000		-	0449260		(=)
Part I Informat on a separa	ion Conce ate Schedule	rning Insurance Contra A. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Com	nmission ported on a	S Provide info single Schedu	ormation for each contract ale A.
1 Coverage Information:							
(a) Name of insurance car KAISER FOUNDATION HE		COLORADO					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			· · · · · · · · · · · · · · · · · · ·	contract year
(b) LIN	code	identification number	policy or contract		(f)	From	(g) To
84-0591617	95669	1095	2126		01/01/202	2	12/31/2022
2 Insurance fee and comr descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total a	mount of con	nmissions paid		(b) To	tal amount	of fees paid	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales an			ees and other commissio				
commissions pai	d	(c) Amount		(d) Purpose			(e) Organization code
	()) !					.,	•
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales an	d base	<u> </u>	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code

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Schedule A (Form 5500) 2	2022	Page 2 – 1			
(a) Na	me and address of the agent, broker	, or other person to whom commis	sions or fees were paid		
		Ease and other commissions paid		(0)	
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid	urpose	(e) Organization	
commissions paid	(c) Amount	(u) 1	шрозс	code	
(a) Na	me and address of the agent, broker	, or other person to whom commis	sions or fees were paid		
		Fees and other commissions paid		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) P	urpose	Organization code	
(a) Na	me and address of the agent, broker	, or other person to whom commis	sions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	urnogo	(e) Organization	
commissions paid	(c) Amount	(u) F	urpose	code	
(a) Na	me and address of the agent, broker	, or other person to whom commis	sions or fees were paid		
42.4		Fees and other commissions paid		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) P	urpose	Organization code	
(a) Na	me and address of the agent, broker	, or other person to whom commis	sions or fees were paid		
		The standard of the standard o			
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid	urpose	(e) Organization	
commissions paid	(C) Amount	(d) P	uipos c	code	

Page **3**

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carr	ier may be treated as a unit fo	or purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	C	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount	•	100	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	intained in separate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))			0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		>			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	•	Saladis at the one of the outline your (outline rote) from the ru)			

Page 4

	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.										
8	Ben	_	nd contract type (check all applicable boxes)		=		_	1		_	
	a >	K He	alth (other than dental or vision)	b	Dental		С	Vision		d∐∟	ife insurance
	е	Te	mporary disability (accident and sickness)	f	Long-term disabili	ty	g	Supplemental unem	ployment	h P	rescription drug
	iΪ	Sto	op loss (large deductible)	i	HMO contract		k	PPO contract		ı∏ır	demnity contract
	m	_	her (specify)	<i>,</i>	_		L			Ш	,
	[ال ال	ner (specify)								
0	Evno	riona	ce-rated contracts:								
	•		iums: (1) Amount received			9a(1)				-	
			` '			9a(2)				-	
			ncrease (decrease) in amount due but unpaid			9a(2)					
		` '	ncrease (decrease) in unearned premium res				_		00/4)		0
	_		arned ((1) + (2) - (3))						. 9a(4)		
	b		efit charges (1) Claims paid			9b(1)					
		` '	ncrease (decrease) in claim reserves			9b(2)			0h/2)		0
		` '	ncurred claims (add (1) and (2))						9b(3) 9b(4)	+	
		` '	claims charged(1) Detaction of account (2)						90(4)		
	С		nainder of premium: (1) Retention charges (o		,	9c(1)(۸١				
			(A) Commissions			9c(1)(l	_				
		,	(B) Administrative service or other fees			9c(1)(_			_	
			(C) Other specific acquisition costs			9c(1)(I					
			(D) Other expenses			9c(1)(l				_	
			(E) Charges for risks or other centing angles			0-/4\/				-	
			(F) Charges for risks or other contingencies							-	
			(G) Other retention charges(H) Total retention						9c(1)(H)		0
			· ,				_			_	
			Dividends or retroactive rate refunds. (These					•	9c(2)	+	
	d		us of policyholder reserves at end of year: (1		•				9d(1)	+	
		` '	Claim reserves						9d(2)	_	
	_	` '	Other reserves						9d(3)		
10	e No		dends or retroactive rate refunds due. (Do no erience-rated contracts:) IIIC	iude amount entered	ı ın ıme 9	C(2)	.)	9e		
10		•	erience-rated contracts. Il premiums or subscription charges paid to c	orrio	r				10a		40005005
									100	_	12885035
	b Spe	rete	e carrier, service, or other organization incurr ntion of the contract or policy, other than repo ature of costs.						10b		
Př	art I	IV	Provision of Information								
			insurance company fail to provide any inform	ation	necessary to compl	ete Sche	dule	А?	Yes	X No	
			swer to line 11 is "Yes," specify the informati							<u> </u>	

SCHEDULE	Α
(Form 5500))

Insurance 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

Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.									
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Fo	rm is Open to Public Inspection					
For calendar plan year 202	22 or fiscal pla	an year beginning 01/01/2022		and en	nding 12/3	31/2022	_		
A Name of plan WELLS FARGO & CO HE DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMPL	LOYEES & THEIR		e-digit number (Pl	N) •	537		
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500		D Emplo	ver Identific	ation Number	(FIN)		
WELLS FARGO & COMP		10 24 011 01111 0000		-	0449260		(=)		
Part I Informat on a separa	ion Conce ate Schedule /	rning Insurance Contra A. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con	nmission ported on a	S Provide info single Schedu	ormation for each contract ale A.		
1 Coverage Information:									
(a) Name of insurance ca		OF THE MID-ATLANTIC			Γ	D. F.			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			· · · · · · · · · · · · · · · · · · ·	contract year		
(-,	code	identification number	policy or contrac		(f)	From	(g) To		
52-0954463	95639	26255	525	525 01/0		2	12/31/2022		
2 Insurance fee and communication descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in		
(a) Total a	amount of com	nmissions paid		(b) To	otal amount	of fees paid			
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).					
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid			
(b) Amount of sales ar			ees and other commissio						
commissions pai	id	(c) Amount		(d) Purpose			(e) Organization code		
	()) !								
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid									
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid					
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code		

CASE 0:24	-CV-03043-LMP-DTS	Doc. 39-6 Filed 11/08/24	Page 18 01 72	
Schedule A (Form 5500) 2	2022	Page 2 – 1		
(a) Na	me and address of the agent, broker	, or other person to whom commissions	or fees were paid	
χω,	no and address of the agent, broker	, or early person to amon commissions	or roco word pand	
		Fees and other commissions paid		(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpos	e	Organization code
(a) Na	me and address of the agent, broker	, or other person to whom commissions	or fees were paid	
(h) Amount of color and have		Fees and other commissions paid		(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpos	е	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions	or fees were paid	
		Fees and other commissions paid		(e)
(b) Amount of sales and base			•	Organization
commissions paid	(c) Amount	(d) Purpos	e	code
(a) No.	mo and address of the agent, broker	r, or other person to whom commissions	or foos wore paid	
χα) του	no and address of the agent, broken	, or early person to whom commissions	or rees were paid	
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpos	е	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions	or fees were paid	

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

Page **3**

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each carrier n	may be treated as a unit t	for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
_		racts With Allocated Funds:		-	
٠	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	nection with the acquisition or	6d	
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	l annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here	7	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
•	a		te participation guarantee		
	а		te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)	10	
	U	(2) Dividends and credits	7c(2)		
			7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
		(5) Other (specify below)	70(3)		
		,			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		>			
		/5) Total daductions		70(5)	
		(B) LOIGH GOGHCTIONS		(6131	()

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Part III Welfare Benefit Contract Informatio If more than one contract covers the same grou		e same emp	lover(s) or members of	of the same en	nplovee organizations(s).
the information may be combined for reporting p	ourposes if such con	tracts are ex	perience-rated as a u	nit. Where co	ntracts cover individual
employees, the entire group of such individual of	ontracts with each c	arrier may be	e treated as a unit for	purposes of th	iis report.
8 Benefit and contract type (check all applicable boxes)	-	·	_		
a X Health (other than dental or vision) b	Dental	С	Vision		d Life insurance
e Temporary disability (accident and sickness) f	Long-term disabil	ity g	Supplemental une	mployment	h Prescription drug
i Stop loss (large deductible)	HMO contract	k	PPO contract		I Indemnity contract
m ☐ Other (specify)	_	L			
iii Galloi (Speedily)					
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)			
(2) Increase (decrease) in amount due but unpaid					
(3) Increase (decrease) in unearned premium reserve		9a(3)			-
(4) Earned ((1) + (2) - (3))				9a(4)	0
b Benefit charges (1) Claims paid		9b(1)		,	
(2) Increase (decrease) in claim reserves					
(3) Incurred claims (add (1) and (2))				. 9b(3)	0
(4) Claims charged				. 9b(4)	
c Remainder of premium: (1) Retention charges (on an	accrual basis)				
(A) Commissions		9c(1)(A)			
(B) Administrative service or other fees		9c(1)(B)			
(C) Other specific acquisition costs		9c(1)(C)			
(D) Other expenses		9c(1)(D)			
(E) Taxes		9c(1)(E)			
(F) Charges for risks or other contingencies		9c(1)(F)			
(G) Other retention charges		9c(1)(G)		1	
(H) Total retention	_				0
(2) Dividends or retroactive rate refunds. (These amo	ounts were paid i	n cash, or	credited.)	· 9c(2)	
d Status of policyholder reserves at end of year: (1) Am	ount held to provide	benefits afte	er retirement		
(2) Claim reserves					
(3) Other reserves				- · · ·	
e Dividends or retroactive rate refunds due. (Do not inc	clude amount entere	d in line 9c(2	2) .)	9e	
10 Nonexperience-rated contracts:					
Total premiums or subscription charges paid to carrie	r			10a	2782650
b If the carrier, service, or other organization incurred a	ny specific costs in o	connection w	ith the acquisition or	10b	
retention of the contract or policy, other than reported Specify nature of costs.	in Part I, line 2 abov	ve, report arr	iount	100	
eposity flataro er ecoto.					
Part IV Provision of Information					
	necessary to comp	lata Schodul	ь 42	Yes	X No
1 / 1		iete ochedul	E A!	103	140
12 If the answer to line 11 is "Yes," specify the information n	ot provided. 🕨				

SCHEDULE A	
(Form 5500)	

Insurance 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

Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.									
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This		m is Open to Public Inspection				
For calendar plan year 202	22 or fiscal pla	an year beginning 01/01/2022	2		and en	ding 12/3	31/2022		
A Name of plan WELLS FARGO & CO HE DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMPI	PLOYE	ES & THEIR	B Three plan	e-digit number (Pl	N) •		537
C Plan sponsor's name as shown on line 2a of Form 5500 WELLS FARGO & COMPANY						yer Identific 0449260	ation Numl	ber ((EIN)
		rning Insurance Contra A. Individual contracts grouped							
1 Coverage Information:									
(a) Name of insurance car KAISER FOUNDATION HE		, INC.							
/L\ FINI	(c) NAIC	(d) Contract or		(e) Approximate nu			Policy	or co	ontract year
(b) EIN	code	identification number		persons covered at policy or contract		(f)	From		(g) To
94-1340523	00000	1915		13002		01/01/202	2		12/31/2022
2 Insurance fee and communication descending order of the		nation. Enter the total fees and t	total co	ommissions paid. Li	st in line 3	the agents,	brokers, aı	nd o	ther persons in
(a) Total a	amount of con	nmissions paid			(b) To	tal amount	of fees paid	<u>d</u>	
3 Persons receiving com	missions and	fees. (Complete as many entri	ies as r	needed to report all բ	persons).				
	(a) Name	and address of the agent, broke	er, or c	other person to whor	n commiss	ons or fees	were paid		
(b) Amount of sales ar		F	Fees ar	nd other commission	•				
commissions pai	id	(c) Amount			(d) Purpose	9			(e) Organization code
	(a) Name	and address of the agent, broke	er, or c	other person to whor	n commiss	ions or fees	were paid		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid									
(b) Amount of sales ar	nd base	F	Fees ar	nd other commissior	ns paid		-		
commissions pai		(c) Amount			(d) Purpose	9			(e) Organization code

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Scriedule A (Form 5500) 2	2022	Page Z =					
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
(5)		,					
Fees and other commissions paid							
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
commissions paid	()		code				
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid					
(h) Amount of colon and have		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) No.	me and address of the agent broken	r, or other person to whom commissions or fees were paid					
(a) Nai	The and address of the agent, broker	, or other person to whom commissions or rees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization				
commissions paid	(c) / uno uno	(L) Lapes	code				
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid					
			1				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	me and address of the agent broker	r, or other person to whom commissions or fees were paid	•				
(a) Nai	The and address of the agent, broker	, or other person to whom commissions or rees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization				
commissions paid	(O) / WINSON	(4) (4)	code				

Page **3**

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each carrier n	may be treated as a unit t	for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
_		racts With Allocated Funds:		-	
٠	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	nection with the acquisition or	6d	
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	l annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here	7	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
•	a		te participation guarantee		
	а		te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)	10	
	U	(2) Dividends and credits	7c(2)		
			7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
		(5) Other (specify below)	70(3)		
		,			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		>			
		/5) Total daductions		70(5)	
		(B) LOIGH GOGHCTIONS		(6131	()

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.					
Benefit and contract type (check all applicable boxes)	, ,				
	c Vision	d Life insurance			
	片	片			
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabil	· · · · · · · · · · · · · · · · · · ·	ployment h Prescription drug			
i Stop loss (large deductible)	k ☐ PPO contract	I			
m ☐ Other (specify) ▶					
9 Experience-rated contracts:					
a Premiums: (1) Amount received	9a(1)				
(2) Increase (decrease) in amount due but unpaid	9a(2)				
(3) Increase (decrease) in unearned premium reserve	- 1-1				
(4) Earned ((1) + (2) - (3))		9a(4) 0			
b Benefit charges (1) Claims paid	9b(1)				
(2) Increase (decrease) in claim reserves	21 (2)				
(3) Incurred claims (add (1) and (2))		9b(3) 0			
(4) Claims charged		9b(4)			
C Remainder of premium: (1) Retention charges (on an accrual basis)					
(A) Commissions	9c(1)(A)				
(B) Administrative service or other fees	9c(1)(B)				
(C) Other specific acquisition costs	9c(1)(C)				
(D) Other expenses	9c(1)(D)				
(E) Taxes	9c(1)(E)				
(F) Charges for risks or other contingencies	9c(1)(F)				
(G) Other retention charges	9c(1)(G)				
(H) Total retention		9c(1)(H) 0			
(2) Dividends or retroactive rate refunds. (These amounts were paid in	n cash, or credited.)	9c(2)			
d Status of policyholder reserves at end of year: (1) Amount held to provide		9d(1)			
(2) Claim reserves		9d(2)			
(3) Other reserves		9d(3)			
e Dividends or retroactive rate refunds due. (Do not include amount entered		9e			
10 Nonexperience-rated contracts:	. , ,				
a Total premiums or subscription charges paid to carrier		10a 82406495			
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount					
Specify nature of costs.					
Part IV Provision of Information					
11 Did the insurance company fail to provide any information necessary to comp	lete Schedule A?	Yes X No			
12 If the answer to line 11 is "Ves" specify the information not provided	<u> </u>				

SCHEDULE	Α
(Form 5500))

Insurance 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

Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	m is Open to Public Inspection			
For calendar plan year 202	22 or fiscal pl	an year beginning 01/01/2022		and endin	ng 12/31	/2022	
A Name of plan WELLS FARGO & CO HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR DEPENDENTS) B Three-digit plan number (PN) ▶ 537					537		
C Plan enoneor's name as	e ehown on li	ne 2a of Form 5500		D Employer	r Identificat	tion Number	(FINI)
C Plan sponsor's name as shown on line 2a of Form 5500 WELLS FARGO & COMPANY D Employer Identification Number (EIN) 41-0449260					Livy		
Part I Informati on a separa	ion Conce te Schedule	erning Insurance Contra A. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Comm	nissions ted on a si	Provide info	rmation for each contract e A.
1 Coverage Information:							
(a) Name of insurance car KAISER FOUNDATION HE		NORTHWEST				Deliana	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a				ontract year
(0)	code	identification number	policy or contrac		(f) F	rom	(g) To
93-0798039	95540	1310	2285	0	1/01/2022		12/31/2022
2 Insurance fee and comm descending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in line 3 the	e agents, b	rokers, and o	ther persons in
(a) Total a	mount of cor	nmissions paid		(b) Total	l amount of	fees paid	
3 Persons receiving comm		fees. (Complete as many entrie	'	. ,			
	(a) Name	and address of the agent, broke	er, or other person to who	m commission	is or fees w	vere paid	
							_
(b) Amount of sales and			ees and other commissio	· ·			(-) (
commissions paid	u .	(c) Amount	(d) Purpose			(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	m commission	ns or fees w	vere paid	
(b) Amount of sales and	d hase	F	ees and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code

CASE 0:24	-CV-U3U43-LIVIP-DTS	Doc. 39-6 Filed 11/08/24 Pa	ige 26 01 72
Schedule A (Form 5500) 2	2022	Page 2 – 1	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees w	vere paid
	•		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees w	vere paid
(b) Associated color and become		Fees and other commissions paid	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees w	vere paid
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization code
commissions paid	(c)	(*,7 * **,7 **)	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees w	vere paid
(h) Amount of color and have		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees w	vere paid
, ,	<u> </u>		

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

Page 3

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each carrier n	may be treated as a unit t	for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
_		racts With Allocated Funds:		-	
٠	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	nection with the acquisition or	6d	
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	l annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here	7	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
•	a		te participation guarantee		
	а		te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)	10	
	U	(2) Dividends and credits	7c(2)		
			7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
		(5) Other (specify below)	70(3)		
		,			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		>			
		/5) Total daductions		70(5)	
		(B) LOIGH GOGHCTIONS		(6131	()

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

Page **4**

Page 28 of 72

Part II	I Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	group of employees of th ting purposes if such con	tracts are ex	perience-rated as a uni	t. Where co	ontracts cover individual
8 Bene	fit and contract type (check all applicable boxes)					
a X	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental unem	plovment	h Prescription drug
: -	Stop loss (large deductible)	j X HMO contract	··› sլ		p.0,	
' <u> </u>	, ,	nivio contract	^ [PPO contract		I Indemnity contract
m _	Other (specify)					
9 Expe	ience-rated contracts:			1		
a P	remiums: (1) Amount received		9a(1)			
(Increase (decrease) in amount due but unpaid	d	9a(2)			
	3) Increase (decrease) in unearned premium res				T	
_	4) Earned ((1) + (2) - (3))				. 9a(4)	0
	Benefit charges (1) Claims paid		9b(1)			
,	2) Increase (decrease) in claim reserves				21 (2)	0
	3) Incurred claims (add (1) and (2))				9b(3)	0
	4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (or	,	0.(4)(4)			
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			
	(C) Other specific acquisition costs		9c(1)(D)			
	(D) Other expenses		9c(1)(E)			
	(E) Taxes		0~(4)/[]			
	(F) Charges for risks or other contingencies (G) Other retention charges		2 (1)(2)			
	(H) Total retention(H)				9c(1)(H)	0
	` '					
	(2) Dividends or retroactive rate refunds. (These	ш -	<u></u>	•	9c(2)	
	Status of policyholder reserves at end of year: (1)				9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
	Dividends or retroactive rate refunds due. (Do no	ot include amount entere	a in line 9c(2	2) .)	9e	
	experience-rated contracts:	i			100	
_	Total premiums or subscription charges paid to ca				10a	15943066
	If the carrier, service, or other organization incurre retention of the contract or policy, other than reporting ify nature of costs.				10b	
Part I	/ Provision of Information					_
11 Did	the insurance company fail to provide any inform	nation necessary to comp	lete Schedul	le A?	Yes	X No
		12 If the answer to line 11 is "Ves " specify the information not provided				

SCHED	UL	_E	A
(Form	55	00)

Insurance 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

Department of Labor Employee Benefits Security Adn	Department of Labor polyee Benefits Security Administration File as an attachment to Form 5500.					
Pension Benefit Guaranty Cor	► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Fo			rm is Open to Public Inspection		
For calendar plan year 202	22 or fiscal pla	in year beginning 01/01/2022		and ending 12	2/31/2022	
A Name of plan				B Three-digit		
WELLS FARGO & CO HE DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMPI	LOYEES & THEIR	plan number (PN)	537
C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN)						(EIN)
WELLS FARGO & COMPANY 41-0449260					(,	
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:						
(a) Name of insurance car KAISER FOUNDATION HE	EALTH PLAN,		(e) Approximate nu	umber of	Policy or (contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	it end of	f) From	(g) To
		Tachtineation named	policy or contrac	t year '	17 110111	(9) 10
94-1340523	00000	101872	10719	01/01/20)22	12/31/2022
descending order of the	amount paid.	nation. Enter the total fees and t	otal commissions paid. L	ist in line 3 the agent (b) Total amour		other persons in
(3)				(0)		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	nersons)		
T Grooms receiving comm		and address of the agent, broke			es were paid	
(b) Amount of sales an			ees and other commission			
commissions pai	d	(c) Amount		(d) Purpose		(e) Organization code
	(a) Name	and address of the agent, broke	er or other person to who	m commissions or fee	es were naid	
	(a) Name	and address of the agent, block	or, or ource person to who	m commissions of tea	sa were paid	
(b) Amount of sales an	nd base	F	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpose		(e) Organization code

			7.72
Schedule A (Form 5500) 2	2022	Page 2 – 1	
(a) Na	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			3335
(a) Na	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, by	roker, or other person to whom commissions or fees were paid	
(4)		,	

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

Page **3**

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each carrier n	nay be treated as a unit	for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year e	nd	4	
		rent value of plan's interest under this contract in separate accounts at year en			
_		tracts With Allocated Funds:		•	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year			
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount				6d	
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	annuity	_	
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in separate accounts)	_	
	а		e participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
				7-(0)	
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)	0

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Part III Welfare Benefit Contract Information Figure 1 Welfare Benefit Contract Covers the same		e same empl	over(s) or members o	of the same en	nplovee organizations(s)
the information may be combined for repor	ing purposes if such con	tracts are exp	perience-rated as a ur	nit. Where cor	ntracts cover individual
employees, the entire group of such individ	ual contracts with each o	arrier may be	treated as a unit for	purposes of th	is report.
8 Benefit and contract type (check all applicable boxes)	_	_	_		_
a X Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
e Temporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental uner	mployment	h Prescription drug
i Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract
m ☐ Other (specify) ▶	• 🗆	L			□ ,
THE Other (Specify)					
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)			
(2) Increase (decrease) in amount due but unpaid					
(3) Increase (decrease) in unearned premium res		9a(3)			
(4) Earned ((1) + (2) - (3))			<u> </u>	9a(4)	0
b Benefit charges (1) Claims paid		9b(1)			
(2) Increase (decrease) in claim reserves					
(3) Incurred claims (add (1) and (2))				. 9b(3)	0
(4) Claims charged					
c Remainder of premium: (1) Retention charges (c	n an accrual basis)				
(A) Commissions	······································	9c(1)(A)			
(B) Administrative service or other fees		9c(1)(B)			
(C) Other specific acquisition costs		9c(1)(C)			
(D) Other expenses		9c(1)(D)			
(E) Taxes		9c(1)(E)			
(F) Charges for risks or other contingencies.		9c(1)(F)			
(G) Other retention charges		9c(1)(G)			
(H) Total retention				9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These	amounts were paid i	n cash, or	credited.)	9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide	benefits afte	r retirement	. 9d(1)	
(2) Claim reserves				. 9d(2)	
(3) Other reserves				. 9d(3)	
e Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2)) .)	. 9e	
10 Nonexperience-rated contracts:					
a Total premiums or subscription charges paid to o	arrier			. 10a	52450192
b If the carrier, service, or other organization incur	red any specific costs in o	connection wi	th the acquisition or		
retention of the contract or policy, other than rep	orted in Part I, line 2 abo	ve, report am	ount	. 10b	
Specify nature of costs.					
Don't IV Duoy-inition of Information					
Part IV Provision of Information				7	
11 Did the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	e A?	Yes	X No
12 If the answer to line 11 is "Yes," specify the informat	12 If the answer to line 11 is "Yes," specify the information not provided.				

SCHEDU	JLE A
(Form 5	5500)

Insurance 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

Department of Labor Employee Benefits Security Ad		File as ar					
Pension Benefit Guaranty Co	rporation	Insurance companie pursuant to	This Form is Open to Public Inspection				
For calendar plan year 20	22 or fiscal pl	an year beginning 01/01/2022		and en	ding 12/3	1/2022	
A Name of plan WELLS FARGO & CO H DEPENDENTS)	EALTH PLAN	I (FOR ELIGIBLE ACTIVE EMPI	LOYEES & THEIR	DYEES & THEIR B Three-digit plan number (PN)			
C Plan sponsor's name a	s shown on I	ine 2a of Form 5500		D Emplo	ver Identific	ation Number	(FIN)
WELLS FARGO & COMP		24 6. 1 6 6666		-	0449260	augii Maiiboi	(=)
		erning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		WASHINGTON					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	ontract year
(b) EIN	code	identification number	policy or contract		(f)	From	(g) To
91-0511770	95672	1907200	411		01/01/2022	2	12/31/2022
2 Insurance fee and com descending order of the		mation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of co	mmissions paid		(b) To	otal amount	of fees paid	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar			ees and other commissio		<u> </u>		
commissions pa	id	(c) Amount	(d) Purpose				(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

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Schedule A (Form 5500) 2	2022	Page 2 – 1		
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
()) (
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(h) Amount of color and bacc		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
<i>[]</i>	a ago, 2	, o. o ps.:co		
(la) Assaurat of colors		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

Page 3

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

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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P	art	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group ing pu	of e urpo	ses if such contra	icts are	exp	perience-rated as a ui	nit. Where	contrac	cts cover individual
8	Ben	efit aı	nd contract type (check all applicable boxes)									
-	a	_	ealth (other than dental or vision)	bГ	l De	ental		с	Vision		d	Life insurance
	_ 	=	· ,	_ <u>_</u>	_			_ <u> </u>	\		F	J 7
	e	=	emporary disability (accident and sickness)	f	-	ng-term disability	'	g	=	npioymen	. "	Prescription drug
	ַן י	Sto	op loss (large deductible)	jX	H	AO contract		k	PPO contract		I	Indemnity contract
	m	Ot	ther (specify)									
9	Ехре	erienc	ce-rated contracts:			_						
	a I	Prem	iums: (1) Amount received				9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	١			9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve.			9a(3))				
		(4) E	arned ((1) + (2) - (3))							9a(4	1)	0
	b	Ben	efit charges (1) Claims paid				9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves				9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))							. 9b(3	3)	0
		(4) C	Claims charged							. 9b(4	1)	
	C	Rem	nainder of premium: (1) Retention charges (o	n an a	accr	ual basis)						
		((A) Commissions				9c(1)(A)				
		((B) Administrative service or other fees				9c(1)(
		((C) Other specific acquisition costs				9c(1)(
		((D) Other expenses				9c(1)(
		((E) Taxes				9c(1)(l					
		((F) Charges for risks or other contingencies			L	9c(1)(
		((G) Other retention charges				9c(1)(G)				
		((H) Total retention			<u></u>				. 9c(1)	(H)	0
		(2) [Dividends or retroactive rate refunds. (These	amo	unts	were paid in	cash, or	·П	credited.)	9c(2	2)	
	d	Stat	us of policyholder reserves at end of year: (1) Amo	ount	held to provide b	enefits	afte	er retirement	. 9d(1	1)	
		(2) (Claim reserves							. 9d(2	2)	
		(3) (Other reserves							. 9d(3	3)	
	е	Divid	dends or retroactive rate refunds due. (Do no	ot incl	lude	amount entered	in line 9	c(2	2) .)	. 9e		
10	No	nexp	erience-rated contracts:									
	а	Tota	al premiums or subscription charges paid to c	arrier						. 10a	3	2297838
	b	If the	e carrier, service, or other organization incurr	ed ar	ıv sı	pecific costs in co	nnectio	n wi	rith the acquisition or			
		rete	ntion of the contract or policy, other than repo							. 10k)	
	Spe	cify n	nature of costs.									
D	art l	IV	Provision of Information									
		•		_A: -			4- 0-1	a	Г- 42	7 voc	X	lo.
11			insurance company fail to provide any inform				te Sche	dule	le A?	Yes	^ ^	lo
12	If t	he an	nswer to line 11 is "Yes," specify the informati	on no	ot pro	ovided.						

SCHEDULE	Α
(Form 5500))

Insurance 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

Department of Labo Employee Benefits Security Ad		File as a	n attachment to Form 55	00.					
Pension Benefit Guaranty Co	orporation	▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).						m is Open to Public Inspection	
For calendar plan year 20	22 or fiscal pla	an year beginning 01/01/2022		and en	ding 12/3	31/2022			
A Name of plan				B Thre	e-digit				
WELLS FARGO & CO H DEPENDENTS)	EALTH PLAN	(FOR ELIGIBLE ACTIVE EMP	LOYEES & THEIR	plan	number (Pi	N)	<u> </u>	537	
C Plan sponsor's name a	as shown on li	ne 2a of Form 5500		D Emplo	yer Identific	ation Nu	mber	(EIN)	
WELLS FARGO & COMP				_	0449260			,	
Part I Information a separ	tion Conce ate Schedule	rning Insurance Contra A. Individual contracts grouped	ct Coverage, Fees, I as a unit in Parts II and II	and Con	nmission ported on a	S Provide single Sc	e infoi chedul	rmation for each contract le A.	
1 Coverage Information:									
(a) Name of insurance ca		COMPANY, INC.							
/b) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Polic	y or c	contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From		(g) To	
94-0734860	71420	H2001	0		01/01/2022			12/31/2022	
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	total commissions paid. L	st in line 3	the agents,	brokers,	and o	ther persons in	
(a) Total	amount of con	nmissions paid		(b) To	otal amount	of fees pa	aid		
3 Persons receiving com	missions and	fees. (Complete as many entri	es as needed to report all	persons).					
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were pa	id		
(b) Amount of sales a	nd base	F	ees and other commission	ns paid					
commissions pa	id	(c) Amount		(d) Purpose	е			(e) Organization code	
	(a) Name	and address of the agent, broke	er or other nerson to who	m commiss	ions or fees	were na	id		
	(a) Name	and address of the agent, brown	or, or ourse person to who	11 00111111100	10110 01 1000	word pu	<u>u</u>		
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpose	e			(e) Organization code	
					_				

CASE 0:24	-CV-03043-LMP-DTS	Doc. 39-6 Filed 11/08/24	Page 38 01 72		
Schedule A (Form 5500) 2	2022	Page 2 – 1			
(a) Na	me and address of the agent, broker	, or other person to whom commissions	or fees were paid		
(4)		,	5. 1000 Hotel Palla		
		Fees and other commissions paid		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpos	е	Organization code	
(a) Na	me and address of the agent, broker	, or other person to whom commissions	or fees were paid		
(h) Amount of color and have		Fees and other commissions paid		(e) Organization	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpos	е	code	
(a) Na	me and address of the agent, broker	, or other person to whom commissions	or fees were paid		
		Fees and other commissions paid		(e)	
(b) Amount of sales and base			•	Organization	
commissions paid	(c) Amount	(d) Purpos	e	code	
(a) No.	me and address of the agent broker	r, or other person to whom commissions	or food word noid		
(a) Ivai	nie and address of the agent, bloker	, or other person to whom commissions	or rees were paid		
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization	
commissions paid	(c) Amount	(d) Purpos	е	code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions	or fees were paid		

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

Page **3**

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier r	may be treated as a unit f	or purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end	4	
_		rent value of plan's interest under this contract in separate accounts at year e			
		tracts With Allocated Funds:			
Ī	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	٦	
7		tracts With Unallocated Funds (Do not include portions of these contracts ma			
•	a		te participation guarantee		
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•	-3.77		
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			0
		Deductions:			
	-	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		(4) Outor (Specify Delow)	. 5(7)		
		•			
		(5) Total deductions		70(5)	0

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

Schedule A (Form 5500) 2022

Page **4**

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of	the same employer(s) o	r members of the same em	nlovee organizations(s)		
the information may be combined for reporting purposes if such co					
employees, the entire group of such individual contracts with each	carrier may be treated	as a unit for purposes of thi	s report.		
8 Benefit and contract type (check all applicable boxes)	_		_		
a X Health (other than dental or vision) b ☐ Dental	C Vision	C	Life insurance		
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disa	bility g Supple	emental unemployment I	Prescription drug		
i ☐ Stop loss (large deductible) j ☐ HMO contract	k X PPO c	· · ·	I Indemnity contract		
m ☐ Other (specify) ▶	🗆				
III Utilei (specify)					
9 Experience-rated contracts:					
a Premiums: (1) Amount received	9a(1)				
(2) Increase (decrease) in amount due but unpaid					
(3) Increase (decrease) in unearned premium reserve					
(4) Earned ((1) + (2) - (3))		9a(4)	0		
b Benefit charges (1) Claims paid					
(2) Increase (decrease) in claim reserves					
(3) Incurred claims (add (1) and (2))		9b(3)	0		
(4) Claims charged					
c Remainder of premium: (1) Retention charges (on an accrual basis)					
(A) Commissions	9c(1)(A)				
(B) Administrative service or other fees					
(C) Other specific acquisition costs					
(D) Other expenses					
(E) Taxes					
(F) Charges for risks or other contingencies					
(G) Other retention charges		[a 4040			
(H) Total retention	_		0		
(2) Dividends or retroactive rate refunds. (These amounts were _ paid	d in cash, or	.) 9c(2)			
d Status of policyholder reserves at end of year: (1) Amount held to provi					
(2) Claim reserves					
(3) Other reserves					
e Dividends or retroactive rate refunds due. (Do not include amount ente	red in line 9c(2).)	9e			
10 Nonexperience-rated contracts:		100			
Total premiums or subscription charges paid to carrier			6006		
b If the carrier, service, or other organization incurred any specific costs i retention of the contract or policy, other than reported in Part I, line 2 at	n connection with the ac	quisition or10b			
Specify nature of costs.	ove, report amount	100			
-p,					
Part IV Provision of Information					
11 Did the insurance company fail to provide any information necessary to cor	mplete Schedule A?	Yes X	No		
12 If the answer to line 11 is "Yes," specify the information not provided.					

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	This Form is Open to Public	
Pension Benefit Guaranty Corporation	ion			Inspection.	
For calendar plan year 2022 or fiscal pla	n year beginning 01/01/2022		and ending 12/31	/2022	
A Name of plan		В	Three-digit		
WELLS FARGO & CO HEALTH PLAN (DEPENDENTS)	FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR		plan number (PN)	>	537
C Plan sponsor's name as shown on lin	e 2a of Form 5500	D	Employer Identification	on Numbe	er (EIN)
WELLS FARGO & COMPANY			41-0449260		
Part I Service Provider Info	rmation (see instructions)				
or more in total compensation (i.e., me plan during the plan year. If a person	dance with the instructions, to report the information oney or anything else of monetary value) in connect received only eligible indirect compensation for whinclude that person when completing the remainder of	ion with	services rendered to plan received the requ	the plan o	or the person's position with the
1 Information on Persons Rec	eiving Only Eligible Indirect Compens	ation			
	er you are excluding a person from the remainder of		art because they recei	ved only e	eligible
	an received the required disclosures (see instruction			-	
·	·			,	
•	he name and EIN or address of each person providi sation. Complete as many entries as needed (see in	•	•	or the serv	rice providers who
(b) Enter nam	ne and EIN or address of person who provided you	disclosu	res on eligible indirec	compens	sation
(b) Enter nam	ne and EIN or address of person who provided you o	disclosu	res on eligible indirec	compens	sation
(b) Enter nam	ne and EIN or address of person who provided you o	disclosu	res on eligible indirec	compens	sation
(12) = 1101 11011					
(b) Enter name	ne and FIN or address of person who provided you o	disclosu	res on eligible indirec	compens	sation

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Schedule C	(Form 5500) 2022	Page 2- 1
	(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
	· · · · · · · · · · · · · · · · · · ·	

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				r Indirect Compensation ach person receiving, directly or		
(i.e., mon	ney or anything else of			ne plan or their position with the raddress (see instructions)	plan during the plan year. (Se	ee instructions).
UNITED I	HEALTHCARE		(a) Enter hame and Ent of	a dadress (see mendens)		
41-12892	45					
(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	44008535	Yes No X	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)	1	
35-07815	INSURANCE COMPA	NIES, INC.				
(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	42263419	Yes No 🛚	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)	,	
AETNA L	IFE INSURANCE COM	//PANY				
(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	29987896	Yes No X	Yes No		Yes No

Schedule C	/Earm	EE()()	2000
Scriedule C	LEOHII	5500	ZUZZ

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-----------------	---

answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach 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	r address (see instructions)		
EXPRESS	S SCRIPTS					
43-142056	63					
(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	25639955	Yes No X	Yes No		Yes No
			2) Enter name and EIN or	address (see instructions)		
DDMN AS		· ·	-,			
(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	3951220	Yes No 🛚	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
	ERVICE PLAN (VSP)					
06-122784	40 					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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	542723	Yes No 🛚	Yes No		Yes No

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answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).					ee instructions).	
			(a) Enter name and EIN or	r address (see instructions)		
KPMG LLF	P					
13-556520	17					
	T	(4)	(0)	/4\	(~)	(h)
(b) Service Code(s)	Relationship to employer, employer 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?
10 50	NONE	117500	Yes No X	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
		`	- ,			
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(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?
			Yes No	Yes No		Yes No

Schedule C (Form 5500) 2022

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Part I	Service Provider Information (continued)
3. If you rep	orted on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary

or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following

questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source. (c) Enter amount of indirect (a) Enter service provider name as it appears on line 2 (b) Service Codes (see instructions) compensation (e) Describe the indirect compensation, including any (d) Enter name and EIN (address) of source of indirect compensation formula used to determine the service provider's eligibility for or the amount of the indirect compensation. (a) Enter service provider name as it appears on line 2 (b) Service Codes (c) Enter amount of indirect (see instructions) compensation (d) Enter name and EIN (address) of source of indirect compensation (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. (b) Service Codes (c) Enter amount of indirect (a) Enter service provider name as it appears on line 2 (see instructions) compensation (e) Describe the indirect compensation, including any (d) Enter name and EIN (address) of source of indirect compensation formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

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Part II Service Providers Who Fail or Refuse to F	Provide Infe-	mation
4 Provide, to the extent possible, the following information for eac this Schedule.	n service provide	er who failed or refused to provide the information necessary to complete
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide

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Schedule C (Form 5500) 2022

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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)				
а	Name:	(complete and many commercially	b EIN:	
С	Positio	n:		
d	Addres	s:	e Telephone:	
Ex	planatior			
а	Name:		b EIN:	
c	Positio	n.	Ent.	
d	Addres		e Telephone:	
Ex	planation			
а	Name:		b EIN:	
C	Positio	7:		
d	Addres		e Telephone:	
Ex	planatior	:		
а	Name:		b EIN:	
C	Positio	7:		
d	Addres		e Telephone:	
			·	
Ex	planatior			
а	Name:		b EIN:	
C	Positio	n:		
d	Addres		e Telephone:	
			·	
Ex	planatior			

SCHEDULE D (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

DFE/Participating Plan Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2022

This Form is Open to Public Inspection.

F	or calenda	ar plan year 2022 or fiscal p	olan year beginning	01/01/2022	and er	nding 12/31/2022		
١	Name of plan WELLS FARGO & CO HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR DEPENDENTS)				В	Three-digit plan number (PN)	•	537
С	Plan or [OFE sponsor's name as sho	own on line 2a of Fo	orm 5500	D	Employer Identificatio	n Number (EIN)
١	WELLS FARGO & COMPANY					41-0449260		
	Part I			CCTs, PSAs, and 103-12 IEs ed to report all interests in I		pleted by plans and	DFEs)	
а	Name o	f MTIA, CCT, PSA, or 103-	12 IE: WELLS F	ARGO & CO EMPL BENEFIT TRU	JST			
b	Name o	f sponsor of entity listed in	(a): WELLS F	ARGO & COMPANY				
С	EIN-PN	41-0449260-004	d Entity code	e Dollar value of interest in N 103-12 IE at end of year (17	679129
а	Name o	f MTIA, CCT, PSA, or 103-	12 IE:					
b	Name o	f sponsor of entity listed in	(a):					
С	EIN-PN		d Entity code	e Dollar value of interest in N 103-12 IE at end of year (, or		
а	Name o	f MTIA, CCT, PSA, or 103-	12 IE:					
b	Name o	f sponsor of entity listed in	(a):					
С	EIN-PN		d Entity code	e Dollar value of interest in N 103-12 IE at end of year (, or		
а	Name o	f MTIA, CCT, PSA, or 103-	12 IE:					
b	Name o	f sponsor of entity listed in	(a):					
С	EIN-PN		d Entity code	e Dollar value of interest in N 103-12 IE at end of year (, or		
а	Name o	f MTIA, CCT, PSA, or 103-	12 IE:					
b	Name o	f sponsor of entity listed in	(a):					
С	EIN-PN		d Entity code	e Dollar value of interest in N 103-12 IE at end of year (MTIA, CCT, PSA see instructions)	, or		
а	a Name of MTIA, CCT, PSA, or 103-12 IE:							
b	b Name of sponsor of entity listed in (a):							
С	EIN-PN		d Entity code	e Dollar value of interest in N 103-12 IE at end of year (, or		
а	a Name of MTIA, CCT, PSA, or 103-12 IE:							
b	Name o	f sponsor of entity listed in	(a):					
С	EIN-PN		d Entity code	e Dollar value of interest in N 103-12 IE at end of year (

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Schedule D (Form 5500) 2022

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a Name of MTIA, CCT, PSA, or 103-	a Name of MTIA, CCT, PSA, or 103-12 IE:						
b Name of sponsor of entity listed in (a):							
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103-	12 IE:						
b Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103-	12 IE:						
b Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103-	12 IE:						
b Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103-	12 IE:						
b Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103-	12 IE:						
b Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103-	12 IE:						
b Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103-	12 IE:						
b Name of sponsor of entity listed in (a):							
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103-12 IE:							
b Name of sponsor of entity listed in (a):							
C EIN-PN d Entity code e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)							
a Name of MTIA, CCT, PSA, or 103-12 IE:							
b Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					

Schedule D (Form 5500) 2022

Page **3 -** 1

P	art II Information on Participating Plans (to be completed by DFEs) (Complete as many entries as needed to report all participating plans)	
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN
а	Plan name	
b	Name of plan sponsor	C EIN-PN

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

2022

OMB No. 1210-0110

This Form is Open to Public

Pension Benefit Guaranty Corporation	, i no ao an attaonmen	t to 1 omi 0000.			Inspectio	n
For calendar plan year 2022 or fiscal pla	an year beginning 01/01/2022	and ending	g 12/31/2	2022		
A Name of plan		В	Three-dig	it		
WELLS FARGO & CO HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR			plan numl	per (PN)	•	537
DEPENDENTS)						
C Plan sponsor's name as shown on lin	ne 2a of Form 5500	D	Employer I	dentification	n Number (E	ΞIN)
WELLS FARGO & COMPANY			41-04	49260		

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,

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)		

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	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
Pa	rt II Income and Expense Statement			
2	Plan income, expenses, and changes in net assets for the year. Include all incomends) and any payments/receipts to/from insurance carriers. Round off amou complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.			
	Income		(a) Amount	(b) Total

Income		(a) Amount	(b) Total
a 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

Schedule H (Form 5500) 2022

Page 3

			(a) Am	ount		(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)					
(7) Net investment gain (loss) from pooled separate accounts	2b(7)					
(8) Net investment gain (loss) from master trust investment accounts	2b(8)					1335361
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)					
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)					
C Other income	2c					
d Total income. Add all income amounts in column (b) and enter total	2d					2583732474
Expenses						
e Benefit payment and payments to provide benefits:						
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)			22573	34755	
(2) To insurance carriers for the provision of benefits	2e(2)			17309	99403	
(3) Other	2e(3)					
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)					2430434158
f Corrective distributions (see instructions)	2f					
g Certain deemed distributions of participant loans (see instructions)	2g					
h Interest expense	2h					
i Administrative expenses: (1) Professional fees	2i(1)					
(2) Contract administrator fees	2i(2)			1465	13255	
(3) Investment advisory and management fees	2i(3)					
(4) Other	2i(4)					
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)					146513255
j Total expenses. Add all expense amounts in column (b) and enter total	2j					2576947413
Net Income and Reconciliation						
k Net income (loss). Subtract line 2j from line 2d	2k					6785061
I Transfers of assets:						
(1) To this plan	2I(1)					
(2) From this plan	2I(2)					
Part III Accountant's Opinion						
Complete lines 3a through 3c if the opinion of an independent qualified publ	ic accountant	is attached t	to this	Form (5500. Cd	omplete line 3d if an opinion is not
attached. The etterhed entition of an independent qualified public accountant for this.	nlan ia (aaa in	atrications).				
a The attached opinion of an independent qualified public accountant for this point (1) Unmodified (2) Qualified (3) Disclaimer (Adverse	,				
 b Check the appropriate box(es) to indicate whether the IQPA performed an Eperformed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12((1) □ DOL Regulation 2520.103-8 (2) □ DOL Regulation 2520.103-12(d) 	d). Check box	(3) if pursua	ant to r	neither	-	. , , , ,
		OL Regulat	1011 20	∠∪. 10√	J-O HOI L	70L 1169ulation 2020.100-12(0).
C Enter the name and EIN of the accountant (or accounting firm) below:		(2) EINI-	· 40 E	ECEOO	7	
(1) Name: KPMG LLP		(2) EIN:	13-5	56520	/	
d The opinion of an independent qualified public accountant is not attached to (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached to the control of		ovt Form 55	500 pur	cuant	to 20 C	FR 2520.104-50.
	acried to the h	ext Follii 55	oo pui	Suarit	10 29 CI	1 2320.104-30.
Part IV Compliance Questions		- Umar - 4 - 4	1 - 45	1 1'	Ale 4	4
4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs of 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete lin		e iines 4a, 4	ie, 4t, 4 	∔g, 4h,	4K, 4m,	4n, or 5.
During the plan year:		r		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions with position of the plan and participant contributions with position of the plan and participant contributions with participant described in 20 CER 2510.3, 1032 Centings to appropriate and the plan and participant contributions with participant contributions with the plan and participant contributions with participant contributions with the plan and participant contributions with plan and participant contributions with the		iluroo untii				
period described in 29 CFR 2510.3-102? Continue to answer "Yes" for ar fully corrected. (See instructions and DOL's Voluntary Fiduciary Correctic	, ,		4a		X	
•	- /	L				

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			Yes	No	Amo	unt
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans					
	secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X		
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X		
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X		
е	Was this plan covered by a fidelity bond?	4e	X			100000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X		
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X		
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X		
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4ii		X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	4j		X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X		
I	Has the plan failed to provide any benefit when due under the plan?	41		X		
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X		
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n				
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Ye If "Yes," enter the amount of any plan assets that reverted to the employer this year	s X	No			
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide transferred. (See instructions.)	ntify t	he plan	(s) to w	hich assets or liab	ilities were
	5b(1) Name of plan(s)				5b(2) EIN(s)	5b(3) PN(s)
	Nas the plan a defined benefit plan covered under the PBGC insurance program at any time during this nstructions.)		•	(See EF	RISA section 4021	
	f "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan y			<u> </u>	·	

Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

(With Independent Auditors' Report Thereon)



KPMG LLP One Cleveland Center Suite 2600 1375 East Ninth Street Cleveland, OH 44114-1796

Independent Auditors' Report

To the Plan Participants and the Plan Administrator Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents):

Scope and Nature of the ERISA Section 103(a)(3)(C) Audit

We have performed audits of the financial statements of Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents) (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) (ERISA Section 103(a)(3)(C) audit). The financial statements comprise the statements of net assets available for benefits (modified cash basis) as of December 31, 2022 and 2021, and the related statement of changes in net assets available for benefits (modified cash basis) for the year ended December 31, 2022, and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audits of the Plan's financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audits need not extend to any statements or information related to assets held for investment of the Plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained certifications from a qualified institution as of December 31, 2022 and 2021, and for the year ended December 31, 2022, stating that the certified investment information, as described in Note 3 to the financial statements, is complete and accurate.

Opinion

In our opinion, based on our audits and on the procedures performed as described in the Auditors' Responsibilities for the Audit of the Financial Statements section:

- The amounts and disclosures in the accompanying financial statements, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with the modified cash basis of accounting described in Note 2.
- The information in the accompanying financial statements related to assets held by and certified to by a
 qualified institution agrees to, or is derived from, in all material respects, the information prepared and
 certified by an institution that management determined meets the requirements of ERISA
 Section 103(a)(3)(C).





Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our ERISA Section 103(a)(3)(C) audit opinion.

Emphasis of Matter - Basis of Accounting

We draw attention to Note 2 to the financial statements, which describes the basis of accounting. The financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than U.S. generally accepted accounting principles. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the modified cash basis of accounting, as described in Note 2, and for determining that the modified cash basis of accounting is an acceptable basis for the preparation of the financial statements in the circumstances. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. Management's election of the ERISA Section 103(a)(3)(C) audit does not affect management's responsibility for the financial statements.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the Plan, and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditors' Responsibilities for the Audit of the Financial Statements

Except as described in the Scope and Nature of the ERISA Section 103(a)(3)(C) Audit section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or
 error, and design and perform audit procedures responsive to those risks. Such procedures include
 examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

Our audits did not extend to the certified investment information, except for obtaining and reading the certification, comparing the certified investment information with the related information presented and disclosed in the financial statements, and reading the disclosures relating to the certified investment information to assess whether they are in accordance with the presentation and disclosure requirements of the modified cash basis of accounting, as described in Note 2.

Accordingly, the objective of an ERISA Section 103(a)(3)(C) audit is not to express an opinion about whether the financial statements as a whole are presented fairly, in all material respects, in accordance with the modified cash basis of accounting, as described in Note 2.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

KPMG LLP

Cleveland, Ohio September 14, 2023

Statements of Net Assets Available for Benefits (Modified Cash Basis)

December 31, 2022 and 2021

		2022	2021
Assets:			
Plan interest in Master Trust	\$	17,679,129	11,309,280
Cash		1,886,600	1,471,388
Net assets available for benefits	\$_	19,565,729	12,780,668

See accompanying notes to financial statements (modified cash basis).

Statement of Changes in Net Assets Available for Benefits (Modified Cash Basis)

Year ended December 31, 2022

Additions to Plan assets attributed to:		
Plan interest in Master Trust net investment income	\$	1,335,361
Contributions:		
Employer		1,931,456,732
Employee	_	650,940,381
Total contributions	<u>.</u>	2,582,397,113
Total additions		2,583,732,474
Deductions from Plan assets attributed to: Benefit payments, net of rebates Insurance premiums Administrative expenses		2,257,334,755 173,099,403 146,513,255
Total deductions	<u>.</u>	2,576,947,413
Increase in net assets available for benefits		6,785,061
Net assets available for benefits: Beginning of year		12,780,668
	. -	
End of year	\$ _	19,565,729

See accompanying notes to financial statements (modified cash basis).

Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

(1) Description of the Plan

The following description of the Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents) (the "Plan") is provided for general information purposes only. Participants should refer to the Plan document for a more complete description of the Plan's provisions. Wells Fargo & Company ("Wells Fargo" or the "Company") is the Plan Sponsor. Effective July 1, 2022, the Plan is administered by the Plan Sponsor's Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), the Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources over benefit plans and programs other than the Head of Human Resources and the Head of Total Rewards), each of whom, acting individually or jointly, may take action as the Plan Administrator, or its or their authorized delegate.

The Plan was adopted and established effective January 1, 2011 to provide medical, dental, and vision coverage to eligible active employees, their eligible dependents and any related Consolidated Omnibus Budget Reconciliation Act ("COBRA") qualified beneficiaries.

(a) General

The Plan is a combination of self-insured and insured health and welfare benefit options that provides for the payment or reimbursement of all or a portion of covered medical, dental and vision expenses incurred by participating active eligible employees (and their participating eligible dependents) of Wells Fargo or participating employers (collectively, the "Company"). It is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Generally, an employee is eligible to participate in the Plan on the first day of the month following one calendar month of service, if he or she qualifies under one of the following employment classifications:

- (i) Regular and fixed term full-time employees who are regularly scheduled to work 30 hours or more per week.
- (ii) Regular and fixed term part-time employees who are regularly scheduled to work between 17½ and 29 hours per week.
- (iii) Flexible employees and interns are eligible to enroll in medical coverage under the Plan.

Eligible employees may elect to cover their eligible dependents, generally defined as the participating employee's spouse, domestic partner, and eligible children. An employee, in addition to their covered dependents, who ceases to be a participant in the Plan may be entitled to elect and pay for any optional extension of benefits provided under COBRA. The American Rescue Plan Act established a COBRA subsidy program for assistance to eligible individuals. The program was in effect from April 1, 2021 through September 30, 2021.

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Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

(i) Medical Program

The medical program includes medical and prescription drug services through a number of different medical coverage options, including both self-insured and insured medical coverage options as described by the Plan document.

The funding to a certain claims administrator for use of payment of claims is provided each business day via a noninterest bearing account with an imprest cash balance. The cash balance is reflected on the statements of net assets available for benefits.

Participants enrolled in a high deductible health plan option may establish a tax-advantaged savings vehicle known as a Health Savings Account ("HSA") to pay for qualified medical expenses that they or their eligible dependents incur. Contributions to the HSA may be made by the participant or Wells Fargo. The HSA is owned by the participant and is not part of the Plan. Contributions to HSAs and payments of qualified medical expenses from HSAs are not included in the statements of changes in net assets available for benefits.

Participants enrolled in a health reimbursement account ("HRA") plan can receive allocations by participating in certain health and wellness activities. Participants may use their HRA to pay for qualified medical expenses incurred during the plan year. The HRA is a notional account and no specific funds are set aside or otherwise segregated. Amounts allocated to the HRA are not vested and are subject to forfeiture upon coverage termination. Any amounts remaining at the end of the year can generally be carried over to the next year if the participant remains enrolled in an HRA plan option. The notional amount allocated to participant accounts at December 31, 2022 and 2021 was approximately \$65.0 million and \$75.0 million, respectively.

(ii) Dental Program

The dental program offers preventative, restorative, and prosthetic care on a self-insured basis as described in the Plan document. The claims administrator for the dental program has contractual agreements with dentists nationwide. The maximum expense considered for benefits for services received from a participating dentist is the agreed-upon allowable charge between the claims administrator and the participating dentist. The maximum expense for services received from an out-of-network dentist is based on the claim administrator's table of allowances. Participants are responsible for paying the amount in excess of the fee in the table of allowances.

(iii) Vision Program

The vision program provides for the payment or reimbursement of all or a portion of covered expenses for eye examinations and eyeglass frames, lenses, and contacts on a self-insured basis. Benefits differ if participants choose a network provider rather than an out-of-network provider. Each covered participant must generally pay a copayment or coinsurance for each type of covered service provided.

Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

(b) Trust Funds Held by Trustee

The Wells Fargo & Company Employee Benefit Trust ("Master Trust") is used to fund benefits under the Plan. In 2019, Principal Financial Group acquired the Institutional Retirement & Trust business from Wells Fargo Bank, N.A., a participating employer in the Plan. Prior to February 22, 2022, Wells Fargo Bank, N.A. was the qualified certifying institution and trustee for the Trust. Effective February 22, 2022, Delaware Charter Guarantee & Trust Company, conducting business under the trade name "Principal Trust Company", became the new qualified institution and trustee of the Trust. Collectively, the two entities will be known as the "Trustee" throughout this report. The Trustee executes purchases and sales of investments in the Trust pursuant to the direction of the Employee Benefit Review Committee or its agent. The investments of the Trust and changes therein have been reported to the Plan by the Trustee.

(c) Contributions

Participating employees contribute a set amount throughout the Plan year generally via bi-weekly payroll deductions. The Company contributes at a rate that, together with the employee contributions, is sufficient to pay expected claims, premiums, and administrative expenses. The contribution rate is based on the level of coverage and Plan experience and may change in future Plan years.

(d) Benefit Payments

The Plan provides benefit payments to or on behalf of eligible participating employees and their eligible dependents for covered medical, dental and vision expenses, as applicable.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The Plan's policy is to prepare its financial statements on a modified cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America. Under such modified cash basis, financial statements are prepared on the basis of cash receipts and disbursements, except that investments are reported at fair value. Consequently, certain revenues are recognized when received rather than when earned and certain expenses are recognized when paid rather than when the obligations are incurred. Accordingly, the accompanying financial statements are not intended to be a presentation in conformity with accounting principles generally accepted in the United States of America.

(b) Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, benefit obligations and changes therein, claims incurred but not reported, claims payable, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

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Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

(c) Investment Valuation and Income Recognition

The investment in the Master Trust is carried at the current unit value based upon the fair values of the individual investments held by the Master Trust as determined by the Trustee. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold, as well as held during the year.

(d) Risks and Uncertainties

The Plan may invest in various types of investment securities. Investment securities are exposed to various risks, such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and such changes could materially affect the amount reported in the statements of net assets available for benefits.

Plan contributions are made and the actuarial present value of accumulated plan benefits are reported based on certain assumptions pertaining to interest rates, inflation rates, and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

(e) Expenses

Certain Plan administrative expenses such as claims processing, audit and tax preparation fees are paid by the Plan. All fees paid to the Trustee are paid by the Company.

(f) Benefit Payments

Benefit payments are recorded when paid.

(g) Rebates

The Plan utilizes a pharmacy benefit manager ("PBM") to administer its prescription drug benefit. The PBM pays rebates to the Plan based on the Plan's actual utilization pattern of specific drugs. Rebates received from the Plan's PBM are recorded as a reduction of benefit payments.

(3) Information Certified by Trustee

The Plan Administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, as permitted under such election, the Plan Administrator has obtained certifications as of and for the years ended December 31, 2022 and 2021 from the Trustee that all investment information provided by the Trustee is complete and accurate. Investment information included in the accompanying financial statements and notes to the financial statements as to the investment assets held in the Master Trust managed by the Trustee, and investment income is presented in reliance solely upon those certifications.

Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

(4) Plan Interest in Master Trust

The Plan, together with the Wells Fargo & Company Retiree Plan, invests its assets on a commingled basis in the Master Trust. Each participating plan has an undivided interest in the assets of the Master Trust. The fair value of the Plan's interest in the Master Trust is based on the beginning of year value of the Plan's interest in the Master Trust, plus actual employee contributions and allocated employer contributions to the Plan, plus Master Trust investment income allocated to the Plan, less actual distributions and expenses of the Plan. The Plan's interest in the net assets of the Master Trust at December 31, 2022 and 2021 was approximately 71% and 63%, respectively. Investment income and employer contributions are allocated to the individual plans based upon the ratio of annual distributions and benefit expenses by each plan.

The following tables present the net assets, including investments, held in the Master Trust and the Plan's interest in the Master Trust net assets at December 31, 2022 and 2021:

		2022		
	_	Master Trust Balances	Plan's Interest in Master Trust Balances	
Investments at fair value:	_			
Registered investment companies:				
Money market fund	\$	24,697,258	17,438,567	
Accrued income		340,694	240,562	
Net assets	\$	25,037,952	17,679,129	

	2021		
		Plan's Interest	
	Master Trust	in Master	
	Balances	Trust Balances	
Investments at fair value:			
Registered investment companies:			
Money market fund	\$ 17,930,737	11,308,766	
Accrued income	815	514	
Net assets	\$ 17,931,552	11,309,280	

Notes to Financial Statements (Modified Cash Basis) December 31, 2022 and 2021

The net investment income of the Master Trust for the year ended December 31, 2022 is presented below:

	 2022
Investment income:	
Interest and dividends	\$ 1,257,662
Other income	 78,315
Total investment income	\$ 1,335,977

In accordance with the topic of the *Fair Value Measurements and Disclosures*, FASB Codification, assets and liabilities are measured at fair value in three levels based on the markets in which the assets and liabilities are traded and the reliability of the assumptions used to determine fair value. These levels are:

- **Level 1** Valuation is based upon quoted prices for identical assets traded in active markets.
- Level 2 Valuation is based upon quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market.
- Level 3 Valuation is generated from model-based techniques that use significant assumptions not observable in the market. These unobservable assumptions reflect estimates of assumptions that market participants would use in pricing the asset or liability. Valuation techniques include use of discounted cash flow models, market comparable pricing, option models and similar techniques.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The following is a description of the valuation methodologies used by the Master Trust to measure investments at fair value. There have been no changes in the methodologies used at December 31, 2022 and 2021.

Investments in registered investment companies are valued at fair value based upon quoted prices in an active market. Registered investment companies include money market funds, which are priced at \$1.00 per share.

Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

The following table sets forth by level, within the fair value hierarchy, the investments of the Master Trust at fair value as of December 31, 2022 and 2021:

	December 31, 2022				
	-	Level 1	Level 2	Level 3	Total
Registered investment companies: Money market fund	\$_	24,697,258			24,697,258
Total investments at fair value	\$	24,697,258			24,697,258
	_		December	31, 2021	
	_	Level 1	Level 2	Level 3	Total
Registered investment companies: Money market fund	\$_	17,930,737			17,930,737
Total investments at fair value	\$_	17,930,737			17,930,737

(5) Related-Party Transactions

Prior to February 22, 2022, Wells Fargo Bank, N.A. was a related party as Trustee of the Trust. Effective February 22, 2022, Principal Trust Company became the Trustee, and therefore, Wells Fargo Bank, N.A. is no longer a related party as Trustee on the Plan. Transactions related to trustee activity are covered by an exemption from the "prohibited transactions" provisions of ERISA and the Code.

(6) Benefit Obligations

(a) Postemployment Benefit Obligation

The postemployment benefit obligation represents the total actuarial present values of all estimated future benefits that are expected to be paid to those employees or former employees who are currently receiving disability benefits, on COBRA continuation or on Parental leave, reduced by the actuarial present value of contributions expected to be received in the future from current plan participants. The actuarial present values of the expected postemployment benefit obligations are determined by discounting the expected future payment stream for each individual currently receiving disability benefits, taking into account probabilities of death, recovery and increases in future medical costs. Expected annual future medical costs are based on historical per capita medical claims, adjusted to reflect current medical cost trends.

Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

For measurement purposes, the following actuarial assumptions were utilized as of December 31, 2022 and 2021:

	2022	2021
Discount rate -		
Longterm disability	5.20%	0.50%
Termination from disability	2012 Group long-term disability table	2012 Group long-term disability table
Healthcare cost trend rate	7.10% decreasing 0.20% to 0.30% each year to 4.50% in 2032	6.70% decreasing 0.20% to 0.30% each year to 4.50% in 2030
Average participant contributions for medical coverage	25% of medical costs	25% of medical costs

The postemployment benefit obligation also includes a component for employees enrolled in a HRA plan option who may move into postemployment status and receive disability benefits (Postemployment HRA-Balance program).

For measurement purposes, the following actuarial assumptions were utilized for measurement of the Postemployment HRA-Balance liability as of December 31, 2022 and 2021:

	2022	2021
Discount rate - HRA	5.00%	2.00%
HRA benefit obligation	\$ 4,765,000	\$ 6,981,000
Projected post-decrement HRA balance	\$ 920	\$ 970
Mortality rates healthy and disabled	Pri-2012 mortality study projected generationally from 2012 with Scale MP-2021	Pri-2012 mortality study projected generationally from 2012 with Scale MP-2021
Retirement rates	Range of 5% to 100% from age 50 to age 80	Range of 5% to 100% from age 50 to age 80
Withdrawal rates	13% to 45% for ages 25 and less to age 65	13% to 45% for ages 25 and less to age 65

Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

The following table provides additional information regarding the Plan's accumulated postemployment benefit obligation as of December 31, 2022 and 2021:

		2022	2021
Medical continuation for participants on LTD, STD,	_		
Parental Leave or Other Leave of Absence, COBRA			
continuation and employees in Postemployment			
HRA-Balance program	\$	75,877,000	91,370,000

The following provides additional information regarding the Plan's change in the accumulated postemployment benefit obligation for the year ended December 31, 2022:

	 2022
Balance at beginning of year	\$ 91,370,000
Increase (decrease) during the year attributed to:	
Benefits earned	67,289,000
Benefits paid	(81,936,000)
Interest	229,000
Changes in actuarial assumptions*	(1,197,000)
Actuarial experience and other gains and losses	 122,000
Balance at end of year	\$ 75,877,000

^{*} In 2022, changes in actuarial assumptions from January 1, 2022 to December 31, 2022 include the increase of the discount rate for long term disability from 0.50% to 5.20% for the LTD plan, and from 2.00% to 5.00% for the HRA Plan, and the decrease in the projected post-decrement HRA balance from \$970 to \$920.

(b) Other Obligations

Due to the Plan's modified cash basis of accounting, certain claims relating to the years ended December 31, 2022 and 2021 were not paid or accrued as of December 31, 2022 and 2021. Estimated claims incurred but not reported are estimates, which are based on claim run-off experience and are subject to uncertainty.

The following table provides additional information regarding the Plan's other benefit obligations as of December 31, 2022 and 2021:

	2022	2021
Amounts currently payable:		
Claims payable, net of rebates, and claims incurred but not reported	\$ 155,945,000	189,669,000

Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

The following table provides additional information regarding the Plan's changes in the other benefit obligations for the year ended December 31, 2022:

	2022
Amounts currently payable:	
Balance at beginning of year	\$ 189,669,000
Claims reported	2,223,610,755
Claims paid, net of rebates	(2,257,334,755)
Balance at end of year	\$ 155,945,000

The Plan's deficiency of net assets available for benefits over the benefit obligation relates to claims incurred but not reported and the projected benefit obligations as of December 31, 2022 and 2021. The funding of the deficiency will be provided by future employer contributions.

(7) Tax Status

The Master Trust established under the Plan to hold the Plan's assets is qualified pursuant to Section 501(c)(9) of the IRC, and, accordingly, the Master Trust's net investment income is ordinarily exempt from income taxes. The Master Trust has obtained a favorable tax determination letter dated February 27, 1979 from the Internal Revenue Service ("IRS"), and the Plan Sponsor believes that the Master Trust, as amended, continues to qualify and to operate in accordance with applicable provisions of the IRC.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the organization has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan Administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2022, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan Administrator believes it is no longer subject to income tax examinations prior to 2019.

(8) Plan Termination

The Company has voluntarily agreed to make contributions to the Plan. Although the Company has not expressed any intention to do so, the Plan Sponsor has the right under the Plan to modify the benefits provided, to discontinue its contributions at any time, and to terminate the Plan subject to the provisions set forth in ERISA. In the event of termination, assets held by the Master Trust will be used to provide for benefits payable as of the date of such termination and for payment of expenses of the Plan, including expenses of termination. Any assets remaining after such benefits and expenses will be distributed in accordance with the requirements of Section 501(c)(9) of the IRC and the regulations thereunder. If the Plan is terminated, the termination shall not affect the rights of any participant to claim benefits that are payable prior to such termination.

Notes to Financial Statements (Modified Cash Basis)

December 31, 2022 and 2021

(9) Subsequent Events

The Plan has evaluated subsequent events from the statement of net assets available for benefits date through September 14, 2023, the date on which the financial statements were available to be issued. During this period, except as noted below, there have been no material events that would require additional recognition in the financial statements or disclosures to the financial statements.

Effective January 1, 2023, if a new employee enrolls in health benefits during the designated enrollment period, their coverage is effective on their date of hire.