WELLS FARGO

My Benefits at Wells Fargo

A guide to your Wells Fargo benefits

Benefits Book*

Effective January 1, 2022

** For eligible employees on U.S. payroll*

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Information about your plan	Your plan's member services phone number or website (see the applicable chapter in this *Benefits Book* for contact phone number and website information)
Information about employee enrollment, eligibility, making coverage changes, or plan rates and comparisons	HR Services & Support site Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.
Information about COBRA enrollment	BenefitConnect™ | COBRA 1-877-29-COBRA (26272) [(858) 314-5108 International callers only] Relay service calls are accepted. https://cobra.ehr.com
Retiree coverage **(This *Benefits Book* does not contain information about the retiree health care coverage options under the Wells Fargo & Company Retiree Plan.)**	The Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1 Relay service calls are accepted. https://benefitconnect.wf.ehr.com/ess

The basics

Summary Plan Descriptions

This *Benefits Book* contains Summary Plan Descriptions (SPDs) for certain benefit plans that Wells Fargo sponsors to provide certain benefits to eligible employees. SPDs are provided to you at no cost. The *Benefits Book* is also accessible electronically on the HR Services & Support site.

An SPD explains your benefits and rights under the corresponding benefit plan. Every attempt has been made to make the SPDs easy to understand, informative, and as accurate as possible.

The portions of the *Benefits Book* that make up the SPD for each benefit plan and corresponding benefit options are listed in the "Summary Plan Descriptions for each benefit plan" table starting on page 1-48.

Your responsibility

Each covered employee, COBRA participant, and covered dependent is responsible for reading the applicable SPDs and related materials completely and complying with all rules and plan provisions. The plan provisions applicable to the specific benefit option under the benefit plan determine what services and supplies are eligible for benefits; however, you and your provider have the ultimate responsibility for determining what services you will receive.

While reading this material, be aware that:

- The plans are provided as a benefit to eligible employees, eligible former employees who have elected continuation coverage under COBRA (if applicable), and the respective eligible dependents of either of the above. Participation in these plans does not constitute a contract or guarantee of employment with Wells Fargo & Company or its subsidiaries or affiliates. Plan benefits depend on continued eligibility.
- The name "Wells Fargo" as used throughout this document refers to "Wells Fargo & Company."

In case of any conflict between the SPDs in this *Benefits Book* or any other information provided and the official plan document, the official plan document governs. (In some cases, portions of the *Benefits Book* may constitute part of the official plan document.) You may request a copy of the official plan document by submitting a written request to the address below, or you may view the document on-site during regular business hours:

Corporate Benefits Department
Wells Fargo & Company
MAC N9310-110
550 S. 4th Street
Minneapolis, MN 55415

As a participant in certain benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). For a list of specific rights, review the "Your rights under ERISA" section in "Appendix B: Important Notifications and Disclosures." All of the plans described in this *Benefits Book* are ERISA-covered plans except the Wells Fargo & Company Day Care Flexible Spending Account Plan. In addition, the health savings account that may be set up separately is not a Wells Fargo-sponsored plan and is not subject to ERISA. For more information on the health savings accounts, refer to "Appendix C: Health Savings Accounts."

Employment classifications

Employment classifications determine eligibility for most benefits programs, as well as rates for certain benefit plan options. Employment classifications in Workday include worker type, employee type, and time types. See the "Who's eligible to enroll" section on page 1-5 for more information.

Benefit plan options

The benefit plan options that are available to you as an employee vary depending on your employee type in the Wells Fargo Human Capital Management System (HCMS), also known as Workday:

- Regular
- Fixed term
- Flexible
- Intern

Note: The terminology used in Workday for employee classifications may differ from the *Benefits Book*. Eligibility for benefits is based on the terminology and corresponding definitions presented in this *Benefits Book*.

For more information about employment classifications, refer to the "Who's eligible to enroll" section on page 1-5.

Benefit plan options available to regular and fixed term employees

Wells Fargo sponsors a number of benefit plans providing certain benefits to regular and fixed term employees. Some plans may offer more than one type of benefit option. The benefit plans and corresponding benefit options available to regular and fixed term employees are listed below:

- Wells Fargo & Company Health Plan
  - Copay Plan with Health Reimbursement Account (HRA)[1]
  - Higher Use Plan with Health Savings Account (HSA)[1, 2]
  - Lower Use Plan with Health Savings Account (HSA)[1, 2]
  - Narrow Network with Copay Plan[3]
  - Narrow Network Plan with Health Savings Account (HSA)[2,3]
  - HMO — Kaiser (in certain locations)[3]
  - High-Deductible Health Plan (HDHP) — Kaiser (in certain locations)[2,3]
  - POS Kaiser Added Choice — Hawaii (in Hawaii only)[3]
  - Delta Dental Standard
  - Delta Dental Enhanced
  - Vision Service Plan (VSP)
- Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance, for expatriates only)
- Wells Fargo & Company Health Care Flexible Spending Account Plan
  - Full-Purpose Health Care Flexible Spending Account
  - Limited Dental/Vision Flexible Spending Account
- Wells Fargo & Company Day Care Flexible Spending Account Plan
- Wells Fargo & Company Life Insurance Plan
  - Basic Term Life coverage
  - Optional Term Life coverage
  - Spouse/Partner Optional Term Life coverage
  - Dependent Term Life coverage
- Wells Fargo & Company Business Travel Accident (BTA) Plan
- Wells Fargo & Company Accidental Death and Dismemberment (AD&D) Plan
- Wells Fargo & Company Short-Term Disability (STD) Plan
- Wells Fargo & Company Short-Term Disability Top-Up Plan
- Wells Fargo & Company Long-Term Disability (LTD) Plan
  - Basic LTD
  - Optional LTD
- Wells Fargo & Company Legal Services Plan
- Wells Fargo & Company Critical Illness Insurance Plan
  - Basic Critical Illness Insurance
  - Optional Critical Illness Insurance
- Wells Fargo & Company Optional Accident Insurance Plan

Benefit plan option available to interns and flexible employees

Wells Fargo sponsors the following medical plan options for interns and flexible employees.

- Wells Fargo & Company Health Plan
  - Flexible High Deductible Health Plan (Flex HDHP) if you live in the 48 contiguous states or Alaska[1]
  - POS Kaiser Added Choice – Hawaii plan if you live in Hawaii

Interns and flexible employees are not eligible for any other benefit plans or benefit options described in this *Benefits Book*.

1. Including Out of Area.
2. The health savings account you set up separately is not a Wells Fargo-sponsored plan. For more information on the health savings account, refer to "Appendix C: Health Savings Accounts."
3. Eligibility for the Narrow Network and Kaiser medical plans is limited to regular and fixed term employees whose permanent residential address is within the applicable service area.

Eligible employees

Your employment classification, as described below, determines your eligibility to participate in the benefit plans. (Benefit plan options are listed on page 1-4). If you are unsure of your employment classification, view your profile in Workday to verify your employee type and time type or check with your manager. For additional understanding of employee type and time type, see the "Employment classification table" below.

Individuals who work for Wells Fargo are assigned a worker type within the Human Capital Management System (HCMS), also known as Workday; they are either an employee or a contingent resource. Only employees are eligible to participate in the employee benefit plans described in this *Benefits Book*. The employee must be employed by Wells Fargo or a participating subsidiary or affiliate of Wells Fargo, be paid on the Wells Fargo U.S. payroll system, and their income for this employment must be subject to federal income tax withholding. The definition of "employee" does not include (and has not at any time included) a contingent resource or a person during any period when he or she is not classified as a Wells Fargo employee (even if that person is later determined to have been a Wells Fargo employee during that period). **Note:** The terminology used in Workday for employee classifications may differ from the *Benefits Book*. Eligibility for benefits is based on the terminology and corresponding definitions presented in this *Benefits Book*.

Employment classification table (based on employee data in Workday)

Worker type	Employee type	Definition
Employee	Regular	A person who is an employee of Wells Fargo & Company or any of its subsidiaries without special terms or conditions of employment (not a fixed term employee, flexible employee, or intern). Regular employees are generally considered one of the following time types: • Full-time: with standard hours* of 30 or more hours per week. • Part-time: with standard hours* of at least 17.5 and less than 30 hours per week. Standard hours and the number of hours actually worked may vary somewhat for part-time employees in a nonexempt position, depending on business needs.
Employee	Fixed term	A person who is an employee of Wells Fargo & Company or any of its subsidiaries on a time-based assignment with a defined start and end date (unless they're in the flexible or intern classification). Fixed term employees are generally considered one of the following: • Full-time: with standard hours* of 30 or more hours per week. • Part-time: with standard hours* of at least 17.5 and less than 30 hours per week. Standard hours and the number of hours actually worked may vary somewhat for part-time employees in a nonexempt position, depending on business needs.
Employee	Flexible	The "flexible" classification covers several different scenarios. It may refer to employees who: • Work a schedule with standard hours* of less than 17.5 hours per week • Work occasional, irregular hours to fill short-term staffing needs such as PTO, short- term leaves, or periodic work volume increases • Work only certain times of the month or year • Work any number of hours on specific, short-term projects or assignments with a defined end date (but who are not a fixed term employee)
Employee	Intern	Employees who are participating in a formal Wells Fargo internship program regardless of the number of hours they may be scheduled to work.

* A set number of hours that an employee is expected to work each week, as maintained in Workday, the Wells Fargo Human Capital Management System (HCMS). Standard hours are **not** the same as scheduled hours — for example, a regular full-time employee may have standard hours of 35 hours per week but some weeks may only work 29 hours and other weeks may work 40 hours; a fixed term part-time employee may have standard hours of 28 hours per week but some weeks may only work 20 and other weeks may work 32; or a flexible employee may have standard hours of nine hours per week but, based on business needs, may be scheduled for three hours on Monday, Wednesday, and Friday one week and four-and-a-half hours on Tuesday and Thursday the next week.

Note: Regardless of your employment classification, you may not be covered as both an employee and a spouse or domestic partner of another employee, or an employee and a dependent child of another employee, at the same time (except for coverage under the Life Insurance Plan and AD&D Plan).

Additional requirements for the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance

To be eligible for the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance, you must meet the following additional criteria:

- Be a regular or fixed term employee
- Be on an "international assignment" in a country other than the United States, and have an "international assignment agreement" in force (this agreement is not part of this *Benefits Book* or any applicable SPD)

Eligible dependents

Some benefit plans allow you to enroll or cover eligible dependents. When you enroll in one of these benefit plans or corresponding benefit options, you can also enroll or cover your eligible dependents. It is your responsibility to make sure that your dependent meets the eligibility requirements. An eligible dependent can only be enrolled under one employee and anyone covered as a dependent may not also be covered as an employee (except for the Life Insurance Plan and the AD&D Plan).

For the medical, dental, vision, Life Insurance, AD&D, Legal Services, Optional Critical Illness Insurance, and Optional Accident Insurance Plans, dependent eligibility requirements are described in the "Dependent eligibility" table starting on this page. For all other benefit plans and benefit options, see the applicable chapter in this *Benefits Book* for dependent eligibility information regarding those benefit plans and benefit options. Note that some benefit plans do not provide coverage for dependents.

By enrolling your dependents, you are affirming that each dependent that you have enrolled under a plan, meets all applicable eligibility requirements for that plan as stated in the applicable "Eligible dependents" section starting on this page. You acknowledge and agree that a former spouse from whom you are legally separated or divorced, as well as children of your former spouse that you have not legally adopted, are not eligible to be covered as your dependents under the plan, even if you are court-ordered to provide coverage.

If at any time your covered dependent no longer meets applicable eligibility requirements for the plan, you agree to promptly drop your dependent's coverage. Refer to the "Dropping ineligible dependents" section starting on page 1-44 for more information.

Wells Fargo, the Plan Administrator, the claims administrator, and their delegates or representatives reserve the right to periodically audit or request verification that your covered dependents meet applicable eligibility requirements. For more information, see the "Audits of dependent eligibility" section on page 1-9.

Dependent eligibility

For the medical, dental, vision benefit options, and the Life Insurance, AD&D, Legal Services Plans, Optional Critical Illness, and Optional Accident Insurance, eligible dependents include:

Your spouse	• Your current spouse to whom you are legally married under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages • Your current common-law spouse in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages	• Your spouse who is a Wells Fargo employee and is enrolled in the Wells Fargo-sponsored benefit plan or benefit option as an employee* • Your spouse who is enrolled in the Wells Fargo-sponsored benefit plan or benefit option as a dependent of another employee* • Your spouse who is enrolled in a similar benefit option under the Wells Fargo & Company Retiree Plan (such as the medical, dental, or vision benefit options) • Your spouse who is enrolled in a similar benefit option under the Wells Fargo-sponsored benefit plan or benefit option (such as the medical, dental, vision, or Healthcare FSA benefit options) as a COBRA participant or a dependent of a COBRA participant • Your former spouse from whom you are legally separated or divorced, even if you are court-ordered to provide health insurance

* This does not apply to the Life Insurance Plan or the AD&D Plan.

	Eligible	Not eligible
Your domestic partner	• Your current same- or opposite-sex domestic partner to whom you are joined in a civil union (or other similar formal relationship) that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the union was created, but is not denominated or recognized as a marriage under the laws of that state or country • Your current same- or opposite-sex domestic partner with whom you share a domestic partnership (or other similar formal relationship) that is registered by a city, county, state, or country, but is not denominated or recognized as a marriage under the laws of that city, county, state, or country • Your current same- or opposite-sex domestic partner, if both of you meet all of the following requirements: – You and your domestic partner have shared a single, intimate, committed relationship of mutual caring and intend to remain in the relationship indefinitely – You reside together in the same residence and live in a spouse-like relationship – You and your domestic partner are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which you reside – Neither you nor your partner is married to another person under either federal, state, or common law, and neither is a member of another domestic partnership – You and your partner are mentally competent to consent or contract – You are both at least 18 years old – You and your partner are financially inter-dependent, jointly responsible for each other's basic living expenses, and if asked, are able to provide documentation for three of the following: ◦ Joint ownership of real property or a common leasehold interest in real property ◦ Common ownership of an automobile ◦ Joint bank or credit accounts ◦ A will that designates the other as primary beneficiary ◦ A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other ◦ Designation of one partner as holding power of attorney for health care decisions for the other	• Your domestic partner who is a Wells Fargo employee and is enrolled in the Wells Fargo-sponsored benefit plan or benefit option as an employee* • Your domestic partner who is enrolled in the Wells Fargo-sponsored benefit plan or benefit option as a dependent of another employee* • Your domestic partner who is enrolled in a similar benefit option under the Wells Fargo & Company Retiree Plan (such as the medical, dental, or vision benefit options) • Your domestic partner who is enrolled in a similar benefit option under the Wells Fargo-sponsored benefit plan or benefit option (such as the medical, dental, vision, or Healthcare FSA benefit options) as a COBRA participant or a dependent of a COBRA participant • Your former same- or opposite-sex domestic partner from whom you are now separated or the union, domestic partnership, or other recognized formal relationship has been dissolved, even if you are court-ordered to provide health insurance

* This does not apply to the Life Insurance Plan or the AD&D Plan.

	Eligible	Not eligible
Children	• A child who meets one of the following eligibility criteria through the end of the month in which the child turns age 26[1]: – A child who is your or your spouse's or domestic partner's naturally born child – A child who is your or your spouse's or domestic partner's legally adopted child – A child who has been placed with you or your spouse or domestic partner for adoption ("placed" means there is an enforceable legal obligation for total or partial financial support of the child in anticipation of finalizing the adoption of that child) – A child for whom you or your spouse or domestic partner is the court- or agency-appointed legal guardian, legal custodian, or foster parent (see the "Legal guardian, legal custodian, and foster children" section on this page) • A child who meets the above eligibility criteria, is age 26 or older, and is incapacitated (see the "Incapacitated dependent children" section starting on this page)	• A child who is a Wells Fargo employee and is enrolled in the Wells Fargo-sponsored benefit plan or benefit option as an employee[2] • A child who is enrolled in a similar benefit option under the Wells Fargo-sponsored benefit plan or benefit option (such as the medical, dental, vision, or Healthcare FSA benefit options) as a COBRA participant, or as a dependent of a COBRA participant • A child who is age 26 or older, unless incapacitated (see the "Incapacitated dependent children" section starting on this page)

[1] For Optional Critical Illness Insurance and Optional Accident Insurance, additional dependent eligibility criteria may apply (For example, in certain states, you may be able to enroll your grandchildren). See the certificate for details at MetLife: www.metlife.com/mybenefits.com.

[2] This does not apply to the Life Insurance Plan or the AD&D Plan.

Legal guardian, legal custodian, and foster children

A child for whom you are the court- or agency-appointed legal guardian, legal custodian, or foster parent is eligible for coverage until their 26th birthday as noted in the "Children" section of the "Dependent eligibility" table on this page as long as you or your spouse or domestic partner remain the court- or agency-appointed legal guardian, legal custodian, or foster parent and the child is not already determined to be an eligible dependent under the terms of the plan.

Enrollment of a child for whom you become the court- or agency-appointed legal guardian, legal custodian, or foster parent can only be done upon the occurrence of one of the following:

- During your designated enrollment period for newly hired and newly eligible Wells Fargo employees
- During Wells Fargo's Annual Benefits Enrollment
- Within 30 days prior to or 60 days after an applicable Qualified Event or special enrollment right

Enrollment can be done online by using the Add Coverage Birth/Adoption event (adding a new dependent to coverage). If you do not have access to Workday, you must add coverage by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2. You will be asked to provide a copy of the court- or agency-appointed legal guardianship, legal custodianship, or foster child placement documentation to verify your dependent's eligibility at the time of enrollment.

After the child is enrolled, you must also pay the required contributions for the child's coverage; see the "Cost and funding" section on page 1-11 for more information.

Incapacitated dependent children

Coverage is also available for an incapacitated dependent child who meets the criteria of an eligible child as described in the "Children" section of the "Dependent eligibility" table on this page and who also meets all of the following:

- Is unmarried
- Is age 26 or older
- Was "incapacitated" (as defined below) before their 26th birthday and continues to be incapacitated
- Has been continually covered as an eligible dependent under the Wells Fargo & Company Health Plan or other similar health plan coverage since becoming incapacitated

Incapacitated means the eligible child is incapable of self-support and unable to carry out the routine functions of daily living, without assistance, due to a physical or mental disability.

For all enrollments of an incapacitated child, you must be able to show that the child is either considered disabled by the Social Security Administration or both of the following:

- Incapacitated, as certified by the child's physician
- Is your tax dependent under Section 152 of the Internal Revenue Code (contact your tax advisor if you have questions about whether your incapacitated child is a tax dependent)

Requesting enrollment for an incapacitated dependent child is only allowed:

- Within 30 days prior to or 60 days after the end of the month in which the child reaches age 26
- During your designated enrollment period for newly hired and newly eligible Wells Fargo employees
- During Wells Fargo's Annual Benefits Enrollment
- Within 30 days prior to or 60 days after an applicable Qualified Event or special enrollment right

Enrollment cannot be done online and must be completed by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, and returning the Incapacitated Dependent Child Statement form as requested within 30 days from the date Employee Care sends the form to you.

- If you return the completed Incapacitated Dependent Child Statement form within the required time period, the information provided on the form will be evaluated to determine if your dependent meets the criteria for coverage and can be enrolled (or continue coverage). You will be informed of the decision within 10 business days, assuming all information requested is provided.
- If you do not return the form within the required time period, or the form is incomplete, you will not be able to enroll your dependent as an incapacitated dependent and will have to wait for another opportunity to request enrollment.

If your request to enroll (or continue coverage for) an incapacitated dependent child is approved, you must also pay the required contributions for the child's coverage. See the "Cost and funding" section on page 1-11 for more information.

Imputed income

If you are a regular or fixed term employee and cover an eligible incapacitated child who is not your tax dependent, the portion of the company's contribution for medical or dental coverage that is for your incapacitated child's coverage will be considered "imputed income," or taxable income to you for federal income tax purposes (and state and local income tax purposes, if applicable). As a result, you will receive documentation to account for the applicable amount of imputed income.

Federal, state, and local tax laws may differ, so it is important that you consult a tax advisor. Wells Fargo, the plan administrator, the benefit plans, and Employee Care cannot provide tax advice to you.

Ineligible dependents

In addition to those listed as ineligible in the "Dependent eligibility" table starting on page, ineligible dependents include your parents, siblings, and any other person who does not meet the requirements for an eligible dependent.

If your covered dependent becomes an ineligible dependent (for example, loss of foster parent or legal guardianship appointment, divorce of a spouse, legal separation, or any other event that results in a loss of eligibility), you must drop your ineligible dependent from coverage. Refer to the "Dropping ineligible dependents" section starting on page 1-44 for more information. If your coverage is COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA" for information on dropping your ineligible dependent.

To understand the consequences of having an ineligible dependent enrolled in the plan, refer to the "Consequences of fraudulent enrollment" section on this page.

Note: When you enroll a dependent child, you will be required to provide the child's date of birth. With the exception of Dependent Term Life Insurance coverage, Workday and Employee Care will know when a dependent child becomes ineligible due to reaching the maximum age allowed under the plan (age 26, based on the child's date of birth that you provided at enrollment). The child will be deemed ineligible and will be dropped from the applicable medical, dental, vision, optional critical illness, and optional accident insurance coverage at the end of the month in which they turn age 26, regardless of any separate notification requirements for which you are responsible. Also note that you are responsible for dropping Dependent Term Life Insurance coverage, if applicable, at such time that your children become ineligible for the coverage. For more information, refer to "Chapter 7: Life Insurance Plan."

Audits of dependent eligibility

Wells Fargo, the Plan Administrator, the claims administrator, and their delegates or representatives reserve the right to periodically audit or request verification that your covered dependents meet applicable eligibility requirements. An eligibility audit or verification request may be conducted in connection with enrollment or any time after enrollment. If you are asked to participate in an eligibility audit or asked to verify that your covered dependent meets applicable eligibility requirements, you are required to promptly furnish all requested information. Your failure to promptly furnish all requested information may result in termination of your dependent's coverage under the plan and consequences of fraudulent enrollment may apply. Consequences of fraudulent enrollment may also apply if you furnish the requested documentation and it's determined your dependent is not eligible.

Consequences of fraudulent enrollment

If you fraudulently enroll an ineligible individual, intentionally misrepresent a material fact regarding an ineligible individual, or fail to promptly drop coverage for any of your dependents who no longer meet applicable eligibility requirements, any or all of the following consequences may apply:

- Coverage for that individual will be terminated, and coverage termination may be effective retroactively to the last day of the month in which that individual ceased to meet applicable eligibility requirements.
- You may be required to repay all costs incurred by the plan that are associated with the ineligible individual's coverage during the time period in which that individual did not meet applicable eligibility requirements.

- You may be subject to other corrective action, including termination of your employment.
- The ineligible individual may lose the right to continue group health plan coverage under COBRA.

Medical Child Support Orders and National Medical Support Notices — information for Wells Fargo employees

A medical child support order or medical support notice is a court order decree, or judgment, issued by a court or by an administrative agency authorized to issue child support orders under state law, such as a state child support enforcement agency that requires the alternate recipient to be enrolled under your group health coverage. If, as an employee, you are enrolled or are eligible to be enrolled in one of the Wells Fargo-sponsored group health plans, that means that your child, specified in the order, has the right to enroll and receive benefits under your coverage. For the order to be qualified, the plan administrator must determine that the order includes certain information and meets other requirements of the specific group health plan you're enrolled in and applicable law. A qualified medical child support order or notice is also known as QMCSO.

Address to submit an order or notice

A medical child support order or National Medical Support Notice should be submitted to:

Wells Fargo HR Delivery & Service
MAC N9310-117, QMCSO Processing
550 S. 4th Street
Minneapolis, MN 55415

Determining if the order or notice is qualified

The plan administrator delegates Wells Fargo HR Delivery & Service to receive and process the orders.

When Wells Fargo Benefits Operations receives an order, a representative reviews it to ensure that it is qualified and meets all requirements of a QMCSO, including:

- The order is issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under state law
- The order provides all of the following pertinent information:
  - Your child or children (the alternate recipient or recipients) are identified in the order, including the name and last-known mailing address of the child or children (the order may substitute the name and mailing address of a state or local official for the mailing address of an alternate recipient; alternatively, the order may also provide the address for a custodial parent or legal guardian)
  - You (the plan participant) are identified, including your name and last-known mailing address, as the individual required to provide coverage for the alternate recipient
  - A reasonable description of the group health plan coverage that is to be provided to each alternate recipient
  - The time period to which the order applies

In addition, an order submitted as a National Medical Support Notice will contain the following:

- The name of the state child support enforcement agency issuing the order
- Withholding restrictions, if applicable, on amounts of premium payments

If the order or notice is determined to be a QMCSO, the child will be enrolled in the required benefit options with coverage effective on the first of the month following the date the order is determined to be a QMCSO. However, if the order is applicable to a newly hired or newly eligible employee who has not yet satisfied the required waiting period, the employee and child will be enrolled the first of the month following one full calendar month of service with Wells Fargo.

If federal or state withholding allowances apply and the premium amounts exceed applicable federal or state withholding allowances, or Wells Fargo is otherwise unable to withhold the necessary contribution for coverage, coverage will not be provided for the child that is the subject of the order. (Generally, required premiums for an intern or flexible employee will likely exceed any applicable withholding threshold.) The employee may, however, voluntarily consent to the withholding of an amount in excess of applicable withholding limitations to allow for coverage under the order.

In response to the order, required notifications will be sent to the agency and other applicable individuals.

Paying for QMCSO coverage

You, the employee, must pay the applicable premium payments for the required QMCSO coverage. Generally, employees have payments withheld (deducted) from your pay (see the "Paying for coverage – regular and fixed term employees" section on page 1-11 and the "Paying for coverage – interns and flexible employees" section on page 1-13 for more information).

Additional key points about QMCSOs:

- A QMCSO is only valid if you are currently eligible for benefits.
- Additional eligible children not covered by the QMCSO may not be enrolled in your group health plans because of the QMCSO.
- The child identified in the order must meet the plan definition of an eligible dependent child.
- If you are an employee but have not enrolled in a Wells Fargo-sponsored group health plan, you and the child will be enrolled in the plan or plans in which the child is required to be enrolled for which you are eligible. You cannot choose to enroll only your child — you must also be enrolled — because the Health Plan allows coverage for dependents only when the employee participates in the Health Plan. Unless the court or agency specifies another benefit option, you and the alternate recipient (the child) will be enrolled in the following benefit options based on the coverage for which the QMCSO requires the child to be enrolled:
  - If the child is required to be enrolled in medical coverage: Copay Plan with HRA (unless you or the child reside in Hawaii, then medical coverage will be Kaiser POS Added Choice –

Hawaii). **Note:** A child of an intern or flexible employee will be enrolled in the Flex HDHP medical coverage or Kaiser POS Added Choice – Hawaii for those who reside in Hawaii.

  - If the child is required to be enrolled in dental coverage: Delta Dental Standard. **Note:** A child of an intern or flexible employee is not eligible for dental coverage because interns and flexible employees are not eligible for dental coverage.
  - If the child is required to be enrolled in vision coverage: Vision Service Plan (VSP). **Note:** A child of an intern or flexible employee is not eligible for vision coverage because interns and flexible employees are not eligible for vision coverage.

  Wells Fargo HR Delivery & Service will notify you of the benefit plan options that you and the alternate recipient (the child) have been enrolled in as a result of the QMCSO. You will have 60 days from the date of this notification to call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to request a change in your medical or dental plan option if applicable. Changes will be effective the first of the month following your call to Employee Care.

- If you are currently enrolled in a Wells Fargo-sponsored group health plan, the child will be added to the same health plan, if possible.
- If the child does not live with you, your current plan may not be available where your child lives. In this case, if the order has not identified another medical plan option, you and the child will be enrolled in the Copay Plan with HRA, which is available in all 50 states within the United States except Hawaii.
- You cannot drop coverage, including coverage for an alternate recipient, while a QMCSO is in force.
- If you are a regular or fixed term employee, you may change medical plan benefit options during Annual Benefits Enrollment, if the child is an eligible dependent under the new medical plan benefit option, by accessing the benefits enrollment site in Workday, or by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.
- If coverage is provided pursuant to a QMCSO and that QMCSO is terminated by the court or issuing agency, that does not necessarily mean that coverage for you or your otherwise eligible child will end. Except where continuing coverage constitutes a violation of applicable law or issuing agency error (as determined in the discretion of the plan administrator), coverage will generally continue unless you experience a Qualified Event (as described in the SPD) that would allow you to drop your coverage or the child's coverage. You may elect to drop or change coverage during Annual Benefits Enrollment. For more information about changing or dropping coverage, see the "Changing coverage" section starting on page 1-20.

All participants in the Wells Fargo-sponsored group health plans, including children covered as a result of a QMCSO, are entitled to information under ERISA's reporting and disclosure rules. See the "Your rights under ERISA" section in "Appendix B: Important Notifications and Disclosures."

Cost and funding

Cost

Refer to the HR Services & Support site to determine the cost of the coverage you elect. Contributions and premiums differ based on your employment classification:

- Full-time regular or fixed term employee
- Part-time regular or fixed term employee
- Intern or flexible employees

See the "Eligible employees" section on page 1-5 for more information on employment classifications.

Employee contribution or premium amounts may change every plan year and may also vary based on various factors, including the following levels of coverage for medical, dental, or vision benefits:

- You only
- You and spouse or domestic partner
- You and children
- You and spouse or domestic partner and children

For regular and fixed term employees, your contribution or premium amount for medical coverage will also vary based on your compensation category (for more information on compensation categories, see "Medical premium compensation category" in the "Cost" section of "Chapter 2: Medical Plans").

For other benefit plans and options, see the applicable chapters in this *Benefits Book*, for factors that may impact the cost of coverage.

For cost information for COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA."

Paying for coverage – regular and fixed term employees

If you are a regular or fixed term employee, regardless of whether you are full-time or part-time, your contribution or premium for benefits coverage is deducted each pay period during which you are enrolled and are receiving pay. By making your benefit elections (including default or automatic elections) for yourself and your dependents as part of the benefit enrollment process, you authorize your employer to deduct from your pay the necessary contribution and premium amounts for the benefit coverage you elected under the various Wells Fargo & Company employee benefit plans, including deducting from your pay any back contributions or premiums for coverage for which you may be in arrears, to the extent permitted by applicable law.

Any change in contribution or premium due to an employment classification change becomes effective on the first payroll period after an employment classification change is processed on the payroll system. Per-pay-period premiums and cost for coverage are not prorated.

If your pay is not sufficient to cover your costs for your benefit elections, you are still responsible for your contribution or premiums for coverage. Pay adjustments may be allowed to account for retroactive contributions or premiums from future pay. In some cases, you may be set up on a direct billing process to pay your required contributions and premiums on an after-tax basis. If you have an outstanding balance that is past due, an additional contribution of up to the same per-pay-period amount as your current coverage may be deducted from your pay until your outstanding past due balance is zero. If you are no longer enrolled in coverage, a flat amount of up to $125 per pay period will be deducted from your pay until your outstanding past due balance is zero. If you are on a leave of absence, you may be billed directly.

Before-tax contributions

For regular and fixed term employees, contributions for coverage under certain benefit plans are generally deducted from your pay on a before-tax basis, which may lower your taxable income. There are certain exceptions that are listed below. Before-tax contributions are governed by the Wells Fargo & Company Flexible Benefits Plan, which has been established as a "cafeteria plan" pursuant to Section 125 of the Internal Revenue Code. The benefit options for which your contributions or premiums are generally made on a before-tax basis are medical, dental, and vision coverage under the Wells Fargo & Company Health Plan; medical coverage under the Wells Fargo & Company International Plan (if applicable); the Full-Purpose Health Care Flexible Spending Account; the Limited Dental/Vision Flexible Spending Account; and the Day Care Flexible Spending Account.

Exceptions:

- If you cover a domestic partner or their eligible children, your contributions or premiums for those individuals may not be before-tax, and Wells Fargo's contribution toward the cost of coverage for your domestic partner and their eligible children may be considered taxable income to you; see the "Tax implications for domestic partners" section starting on this page and consult a tax advisor.
- If you are a rehired retiree, your cost for medical, dental, and vision coverage under the Wells Fargo & Company Health Plan (or the Wells Fargo & Company International Plan if applicable) will be on an after-tax basis from your date of rehire until the first of the month following one full calendar month of service with Wells Fargo. For example, if you are rehired on February 23, your contributions for your benefit elections will be on an after-tax basis through March 31. Effective April, your contributions for your benefit elections will be on a before-tax basis where applicable.

After-tax contributions

Employee premiums for the following benefit options are only on an after-tax basis:

- Life Insurance Plan — Optional Term Life coverage
- Life Insurance Plan — Spouse/Partner Optional Term Life coverage
- Life Insurance Plan — Dependent Term Life coverage
- Accidental Death and Dismemberment (AD&D) Plan
- Long-Term Disability Plan — Optional LTD
- Legal Services Plan
- Critical Illness Insurance Plan – Optional Critical Illness Insurance coverage
- Optional Accident Insurance Plan

Leaves of absence and your contributions

If you are on a leave of absence, see "Appendix D: Leaves of Absence and Your Benefits" for more information on premium payments and contributions for your benefits.

Tax implications for domestic partners

The information in this section is not intended to provide tax advice. Federal, state, and local tax laws may differ. Consult a tax advisor for information about your specific situation. Wells Fargo, the plan administrator, the benefit plans, representatives of Employee Care, and representatives of Global Payroll Services cannot provide tax advice to you.

Domestic partners

If you are a regular or fixed term employee and elect coverage under the medical, dental, or vision benefit options for your domestic partner or your domestic partner's children, payments for your portion of the cost of coverage (including your dependent children) will be deducted from your pay on a before-tax basis, and payments for the portion of the cost of coverage for your domestic partner and your domestic partner's children will be deducted from your pay on an after-tax basis. If your domestic partner or your domestic partner's children qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable), see the "Qualified dependents under the Internal Revenue Code or state tax law" section on this page and call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

Imputed income

Generally, your domestic partner (see the "Dependent eligibility" table starting on page 1-6 for domestic partner criteria) and your domestic partner's children may not qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable). If that is the case and you receive a company contribution for medical or dental coverage, the portion of the company's contribution that is attributable to your domestic partner's coverage or coverage for that person's children will be considered "imputed income," or taxable income to you, which is also subject to applicable federal, state, local, Social Security, and Medicare taxes. As a result, the taxable income associated with this coverage will be included in your Form W-2.

Qualified dependents under the Internal Revenue Code or state tax law

In certain instances, your domestic partner or your domestic partner's children may qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable). Discuss this situation with a tax advisor to determine whether your domestic partner and your domestic partner's children may qualify as your dependents under the Internal Revenue Code (or state

income tax law, if applicable). If, after discussing this matter with a tax advisor, you determine that your domestic partner and your domestic partner's children qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable), call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to certify that your domestic partner or your domestic partner's children qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable).

Until you certify that your domestic partner or your domestic partner's children are qualified dependents, they will not be treated as a dependent under the Internal Revenue Code (or state income tax law, if applicable).

Paying for coverage – interns and flexible employees

If you are an intern or flexible employee, your premium for benefits coverage is deducted each pay period on an after-tax basis during which you are enrolled and are receiving pay.

By making your benefit elections for yourself and your dependents as part of the benefit enrollment process, you authorize your employer to deduct from your pay the necessary contribution and premium amounts for the benefit coverage you elected. If a full premium payment cannot be deducted, a partial payment will be deducted. If you have an outstanding balance that is past due, an additional contribution of up to the same per-pay-period amount as your current coverage will be deducted from your pay until your outstanding past-due balance is zero. If you are no longer enrolled in coverage, a flat amount of up to $125 per pay period will be deducted from your pay until your outstanding past-due balance is zero.

Funding arrangements for the plans

Most benefit plan options are either self-insured or fully insured. Refer to the "Summary Plan Descriptions for each benefit plan" table starting on page 1-48 to determine if a benefit option is insured or self-insured.

All employee contributions for coverage under the self-insured medical, dental, and vision benefit options, may be deposited into a trust fund, to which Wells Fargo may also make contributions. Claims and expenses associated with these benefit options may be paid out of the trust fund. When benefits are self-insured, generally third-party administrators provide claims administrative services. These third-party administrators are referred to as claims administrators. While these claims administrators are responsible for administering benefits, the benefit plan is responsible for paying claims.

Premiums for HMO coverage or other fully insured coverage may be deposited into a trust fund or paid to the respective HMO or insurer. When benefits are fully insured by an HMO or other insurer, those insurers are fully responsible for administering and paying benefits.

Amounts deposited into a trust fund will be held in accordance with the terms of the trust fund, and those amounts may be used for any health plan purposes. There is no requirement that amounts deposited into a trust fund be held separately or used for a particular benefit option, including the benefit option for which the amount was deposited. No employee, former employee, participant, dependent, or beneficiary will have any right to, or interest in, amounts deposited to a trust fund.

Wells Fargo does not contribute to the flexible spending accounts. All contributions to the Full-Purpose Health Care Flexible Spending Account, the Limited Dental/Vision Flexible Spending Account, and the Day Care Flexible Spending Account are made by the employee and are held as general assets of Wells Fargo.

For information on funding arrangements and benefits under the STD Plan, see "Chapter 10: Short-Term Disability Plan."

All fees and expenses incurred in connection with the operation and administration of the self-insured medical, dental and vision benefits, and STD plan may be paid out of the trust fund or any other asset of the applicable plan to the extent that it is legally permissible for such fees and expenses to be so paid. Alternatively, Wells Fargo may, but is not required to, pay such fees and expenses directly. Wells Fargo may also advance amounts properly payable by the applicable plan or trust and then obtain reimbursement from the plan or trust for such advance.

For benefits not funded through a trust, fees and expenses incurred in connection with the operation and administration of the benefits may be paid out of the assets of the applicable plan to the extent that it is legally permissible for such fees and expenses to be so paid. Alternatively, Wells Fargo may, but is not required to, pay such fees and expenses directly. Wells Fargo may also advance amounts properly payable by the applicable plan and then obtain reimbursement from the plan for such advance.

How to enroll

General information

You may enroll online in the benefit plan options for which you are eligible during your designated enrollment period by accessing Workday. If you are unable to access Workday, you may make your enrollment elections by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, within the designated enrollment period.

You will receive more information about the initial enrollment process separately. If you have not received enrollment information within a couple of weeks of your hire or rehire date, call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

The "When to enroll — when benefits take effect" section starting on page 1-15 outlines the designated enrollment period and the coverage effective date based on your date of hire or rehire, or the date you become newly eligible for different benefits coverage when you have an applicable employment classification change, such as:

- Employment classification change from a regular or fixed term employee to an intern or flexible employee
- Employment classification change from an intern or flexible employee to a regular or fixed term employee

See the applicable "Benefit plan options" section on page 1-4 and the applicable "Initial enrollment – regular and fixed term employees" section on this page or the "Initial enrollment – interns and flexible employees" section on page 1-15 for more information on plan options available to you based on your employment classification (see the "Eligible employees" section on page 1-5 for more information on employment classification). If you are a rehired employee, including an employee who is rehired during a severance eligibility period, see the "Rehired employees" section beginning on page 1-17.

If you want to cover eligible dependents (including a spouse or domestic partner), you must also enroll them during your designated enrollment period. By enrolling a dependent, you are certifying that your dependent meets the stated eligibility requirements; see the "Eligible dependents" section starting on page 1-6. **Note:** If you want to cover an eligible incapacitated dependent child who is age 26 or older, enrollment cannot be done online and must be completed by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, within your designated enrollment period and returning a form.

Your designated enrollment period begins on the date you are hired, rehired, or the date you become newly eligible for different benefits coverage when you have an applicable employment classification change as noted in the "When to enroll — when benefits take effect" section on page 1-15. However, if you were already working for Wells Fargo as a local hire on local payroll (other than U.S. payroll) and you become a localized U.S.-based employee paid on the Wells Fargo U.S. payroll system, you will be contacted by Employee Care to review your applicable benefit plan and enrollment options. Employee Care will coordinate your enrollment period and process your benefit elections.

If you do not enroll during your designated enrollment period (see the "When to enroll — when benefits take effect" section starting on page 1-15), you will miss your opportunity to have benefits that require an election. You will not have another opportunity to enroll in benefits until the next Annual Benefits Enrollment period unless you experience an event that would allow you to enroll outside of the initial designated enrollment period. For more information, see the "Changing coverage" section starting on page 1-20.

Regular and fixed term employees may also be able to change your life insurance coverage or enroll in Optional LTD after your initial designated enrollment period if you are approved under the applicable statement of health or evidence of insurability process. See "Chapter 7: Life Insurance Plan" and "Chapter 12: Long-Term Disability Plan" in this *Benefits Book* for more information.

For enrollment under COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA."

Initial enrollment – regular and fixed term employees

If you are or become a regular or fixed term employee, you are automatically enrolled in the following company-paid benefit options:

- Life Insurance Plan – Basic Term Life coverage
- Business Travel Accident (BTA) Plan
- Short-Term Disability (STD) Plan
- Short-Term Disability Top-Up Plan, as applicable
- Long-Term Disability (LTD) Plan – Basic LTD
- Critical Illness Insurance Plan – Basic Critical Illness Insurance coverage

During your designated enrollment period, regular and fixed term employees are eligible to enroll in the following benefit options:

- Medical
- Dental
- Vision
- Full-Purpose Health Care Flexible Spending Account
- Limited Dental/Vision Flexible Spending Account
- Day Care Flexible Spending Account
- Life Insurance Plan – Optional Term Life
- Life Insurance Plan – Spouse/Partner Optional Term Life
- Life Insurance Plan – Dependent Term Life
- Accidental Death and Dismemberment (AD&D) Plan
- Long-Term Disability (LTD) Plan – Optional LTD
- Legal Services Plan
- Critical Illness Insurance Plan - Optional Critical Illness Insurance coverage
- Optional Accident Insurance Plan

Note: If you are rehired by Wells Fargo as a regular or fixed term employee with a first day of reemployment during your severance eligibility period under the Wells Fargo & Company Severance Plan, your enrollment options are different. See the "Rehired employees" section on page 1-17.

For enrollment under COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA."

Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance

If you become eligible to enroll in the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance, you will receive enrollment materials that provide information about the initial enrollment process, the due date to complete enrollment, and the applicable effective date of coverage. You will not have another opportunity to enroll in benefits until the next Annual Benefits Enrollment period for this plan unless you experience an event that would allow you to enroll outside of the initial designated enrollment period for this plan. See the "Changing coverage" section starting on page 1-20.

Initial enrollment – interns and flexible employees

If you currently are, or at some point become, an intern or flexible employee, you are eligible to enroll in the following benefit options during your designated enrollment period:

- Medical: Flexible High Deductible Health Plan (Flex HDHP) if you live in the 48 contiguous states or Alaska
- Medical: POS Kaiser Added Choice – Hawaii plan if you live in Hawaii

Interns and flexible employees are not eligible for any other benefit plans or benefit options described in this *Benefits Book*.

When to enroll — when benefits take effect

You must enroll during your designated enrollment period:

- For newly hired or rehired employees, you must enroll within the first 30 calendar days (hire or rehire date is included in the 30-day window). For example if you are hired on January 14, you must enroll no later than February 12.
- For employees with an employee type change, you must enroll within the 30 calendar days of your change date. For example, if your employee type changes from flexible to regular effective January 14, you must make your new benefit elections no later than February 12.

Note: Your time to enroll ends at 11:59 p.m. Central time on the last day of the 30-day designated enrollment period. After you make your elections, the online enrollment tool closes. If you need to make a change to your elections and you are still within the 30-day designated enrollment period, you must call Employee Care at 1-877-479-3557, option 2, to request a change. While you may make additional elections, corrections, or changes during your 30-day designated enrollment period, be aware that any elections, changes, or corrections you make may delay your benefits ID cards. Also, your claims administrator may not be aware of your enrollment on the date your benefits take effect.

For most benefit plans for which you are eligible, coverage becomes effective the first of the month following one full calendar month of service with Wells Fargo if you enroll during the 30-day designated enrollment period, with the following exceptions:

- If you are a regular or fixed term employee and are not actively at work on the date coverage would normally begin, your effective date for BTA, AD&D, STD, Basic LTD, Optional LTD, Basic Term Life, Optional Term Life Insurance, Spouse/Partner Optional Term Life Insurance, Dependent Term Life Insurance, Critical Illness Insurance, and Optional Accident Insurance coverage will be delayed until you return to work (you must return to work in a regular or fixed term position).
- Rehired employees with a first day of reemployment during the severance eligibility period under the Wells Fargo & Company Severance Plan, see the "Rehired employees" section on page 1-17.
- Rehired retirees, see the "Rehired retirees" section starting on page 1-17.
- For the effective date of coverage related to an employment classification change such as a regular or fixed term employee to an intern or flexible employee, or an intern or flexible employee to a regular or fixed term employee, see the "Employment classification changes" section on page 1-18.
- The effective date of coverage under the Wells Fargo & Company International Plan will be communicated to you in the enrollment materials you receive when you become eligible for the plan. Generally, coverage becomes effective the first of the month after the effective date of the applicable international assignment agreement (if the effective date of the agreement is the first of the month, coverage is effective the first of that month) provided that the required enrollment paperwork has been submitted by the due date and you have been in a regular or fixed term position for one full calendar month.
- If you are already working for Wells Fargo as a local hire on local payroll (other than U.S. payroll) and you become a localized U.S.-based employee paid on the Wells Fargo U.S. payroll system as a regular or fixed term employee, your coverage under the U.S. benefits as an employee becomes effective the first of the month following the date you become a localized U.S.-based employee. But, if you become a U.S.-based employee on the first of the month, your benefits will become effective that day. However, if you are not actively at work on the date coverage would normally begin, your effective date for BTA, AD&D, STD, Basic LTD, Optional LTD, Basic Term Life, Optional Term Life Insurance, Spouse/Partner Optional Term Life Insurance, Dependent Term Life Insurance, Critical Illness Insurance, and Accident Insurance coverage is delayed until you return to work on U.S. payroll (you must return to work in a regular or fixed term position).
- If you are already working for Wells Fargo as a local hire on local payroll (other than U.S. payroll) and you become a localized U.S.-based employee paid on the Wells Fargo U.S. payroll system as an intern or flexible employee, coverage under the U.S. benefits as an intern or flexible employee becomes effective the first of the month following the date you become a localized U.S.-based employee. But, if you become a U.S.-based employee on the first of the month, your benefits will become effective that day.
- If you were covered under the Wells Fargo & Company International Plan and your international assignment ends, you will be contacted by Employee Care to discuss your medical plan options under the Wells Fargo & Company Health Plan. Your medical coverage under the Health Plan becomes effective the first of the month following the date your international assignment ended.
- For the enrollment period and effective date of COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA."

Review benefit elections after you enroll

Confirm your elections

Once you submit your enrollment elections in Workday, you will be able to view your Benefit Elections in Workday. Read your Benefit Elections carefully to confirm that the elections for you and your dependents are accurate. You may print a copy for your records. You also have the right to request that a paper copy of your Benefits Elections be sent to you at no cost. You may request a paper copy of your Benefits Elections by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2. The requested copy will be the same version available online.

Benefit election corrections for new hires and newly eligible

If you need to make corrections or changes after you have submitted your initial enrollment elections and are still within the 30-day designated enrollment period, you can do so by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2. **Note:** No changes can be made to your enrollment after your 30-day designated enrollment period. However, you may be able to change coverage elections at a later date if you experience a Qualified Event or special enrollment event; see the "Changing coverage" section starting on page 1-20.

Reviews of enrollment and eligibility disputes

Review process

The Wells Fargo-sponsored employee benefit plans must adhere to the enrollment election restrictions of the plans and as required by federal law in order to remain in compliance with regulations that govern the plans.

If you believe you have experienced extraordinary circumstances that caused you or your dependents to miss enrollment, to be enrolled in benefits in error, or to have benefits terminated in error, call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to request a review of your circumstances. If you are dissatisfied with the determination made by Employee Care, you may submit a written request for a review of Employee Care's determination to Corporate Benefits, on behalf of the plan administrator, at the following address:

Corporate Benefits
Wells Fargo & Company
MAC N9310-110
550 S. 4th Street
Minneapolis, MN 55415

Corporate Benefits cannot accept requests sent by fax or email.

Before you send a request to Corporate Benefits for review, Employee Care must have already reviewed your request. Regardless of the timing of your interaction with Employee Care, Corporate Benefits must receive your written request for review within 120 days from the date of the event that would have allowed you to enroll or change your elections, or from the date your coverage was terminated in error. Any requests received after 120 days will not be reviewed.

When you submit your written request to Corporate Benefits, include all of the following:

- The benefit plan or plans that are the subject of your request
- The individual or individuals that are the subject of your request
- Your desired resolution
- An explanation of any extraordinary circumstances you believe should be considered by Corporate Benefits
- Supporting documentation, as applicable, that provides additional clarity and substantiates the extraordinary circumstances at issue

Corporate Benefits, on behalf of the plan administrator, has sole and complete discretionary authority to make decisions relating to eligibility for enrollment in the respective plans and termination of coverage in the respective plans, subject to the terms of applicable plan documents and governing federal law. Inquiries regarding eligibility and enrollment, or termination of coverage that are within the plan administrator's authority, are generally not subject to claims and appeals procedures. Corporate Benefits' determination, on behalf of the plan administrator, is conclusive and binding on all parties and are not subject to further review. Before taking any legal action with respect to an enrollment or election determination, or termination of coverage determination, you must first complete the internal administrative process described above. After completing the process, if you want to take legal action, you must do so within the statute of limitations described in the "Agent for service" section in "Appendix B: Important Notifications and Disclosures."

Payment adjustments for benefit coverage

If the determination results in a change to your benefit elections, and:

- Coverage becomes effective for you, your dependents, or both, whether retroactively or prospectively, you are responsible for all contributions or premiums owed. For more information, refer to the "Cost and funding" section on page 1-11.
- Coverage is retroactively terminated, for you, your dependents, or both, any premiums paid after the coverage end date, for the coverage that is retroactively terminated, may be refunded on a future paycheck. Additional information may be required from you to retroactively terminate your benefits; if this is the case, more information will be provided at the time the determination is communicated.

When coverage begins

The medical, dental, vision, critical illness, and optional accident insurance benefit options have no preexisting condition exclusions.

The effective date for benefits is subject to any applicable actively-at-work requirements, confinement requirements, or other delayed effective date provisions disclosed in the individual chapters of this *Benefits Book*.

New employees

If you enroll in benefits during your designated enrollment period, coverage for most plans begins the first of the month after one full calendar month of service, except as noted in the "When to enroll — when benefits take effect" section on page 1-15. For eligible dependents enrolled during your initial designated enrollment period, their coverage begins when your coverage begins.

Rehired employees

If you were previously employed by Wells Fargo & Company or any of its subsidiaries or affiliates, your employment was terminated, and you are rehired, your benefits enrollment and coverage effective date are handled like a new employee. See the "New employees" section on this page. However, there are certain important exceptions for those individuals who are rehired with a first day of reemployment during their severance eligibility period, as discussed below.

If you are rehired by Wells Fargo as a regular or fixed term employee with a first day of reemployment during your severance eligibility period under the Wells Fargo & Company Severance Plan, benefit plan coverage upon rehire is impacted as follows:

- Enrollment is automatic in the following company-paid benefit options and coverage continues on your first day of reemployment (as it did not lapse while you were receiving severance benefits):
  - Life Insurance Plan – Basic Term Life Coverage
  - Critical Illness Insurance Plan – Basic Critical Illness Insurance Coverage
- If you are rehired within six months of the termination date that triggered your severance eligibility period, enrollment in the following company-paid benefit options is automatic and coverage begins on the date of reemployment:
  - Short-Term Disability (STD) Plan
  - Short-Term Disability Top-Up Plan, as applicable
  - Long-Term Disability (LTD) Plan – Basic LTD

However, for the coverage options listed above, if you are rehired more than six months from your termination date, coverage begins on the first day of the month after one full calendar month of service.

- Enrollment is automatic in the following company-paid benefit options and the coverage begins the first day of the month after one full calendar month of service:
  - Business Travel Accident (BTA) Plan
- Coverage in effect on the day before your rehire date continues as a rehired employee effective on the first day of reemployment, with no lapse in coverage for any of the following benefits and the coverage level in effect on the day before your rehired date shall remain the same when you are rehired (you do not have an opportunity to make a new election upon rehire):
  - Medical
  - Dental
  - Vision
  - Full-Purpose Health Care Flexible Spending Account or Limited Dental/Vision Flexible Spending Account
  - Life Insurance Plan – Optional Term Life*
  - Life Insurance Plan – Spouse/Partner Optional Term Life
  - Life Insurance Plan – Dependent Term Life
  - Accidental Death and Dismemberment (AD&D) Plan
  - Legal Services Plan
  - Critical Illness Insurance Plan – Optional Critical Illness Insurance coverage
  - Optional Accident Insurance Plan

*The dollar value of your Optional Term Life Coverage may differ depending on the covered pay associated with your job as a rehired employee. For more information, see "Chapter 7: Life Insurance Plan".

Note: If you did not have coverage for any of the benefit options listed above on the day before your rehire date, you will not have coverage for these benefits as a rehired employee. You may enroll in coverage for any of these benefit options only where you have an applicable Qualified Event or special enrollment right, or at the next Annual Benefits Enrollment period, as applicable. See the "Changing coverage" section on page 1-20. You may also request late enrollment for the Life Insurance options at any time, see "Chapter 7: Life Insurance Plans" for more information.

- Coverage begins the first of the month after one full calendar month of service for the following if you elect these benefits during your 30-day designated enrollment period as a rehired employee:
  - Day Care Flexible Spending Account
  - Long-Term Disability (LTD) Plan – Optional LTD

Rehired retirees

If you are a retiree who has coverage under the Wells Fargo & Company Retiree Plan (Retiree Plan) and you are rehired, you will not be able to continue your retiree health care coverage under the Retiree Plan. Retiree health coverage terminates the day before your rehire date. However, if your

retiree medical coverage under the Retiree Plan immediately preceding your date of rehire was the UnitedHealthcare Medicare Advantage plan or the Kaiser Senior Advantage plan, your coverage under the Medicare Advantage option will end prospectively at the end of the month of your date of hire or as soon as administratively feasible, in accordance with CMS guidelines. This means you may have coverage under both Retiree Plan and the Wells Fargo & Company Health Plan (Health Plan) plans for a short period of time. During any overlap period where you have coverage under both plans, the Health Plan is the primary plan. This means health care providers and pharmacies should submit claims first to the Health Plan and second to the Retiree Plan. For additional information on the Retiree Plan, refer to the *Retiree Benefits Book*. The terms of the Retiree Plan and any information provided within the *Retiree Benefits Book* are not part of any of the benefit plans summarized in this *Benefits Book*.

Generally, your coverage as an employee begins the first of the month after one full calendar month of service in your regular or fixed term position, except as noted below:

- If you are a retiree who has coverage under the Retiree Plan that terminates the day before your rehire date, your medical, dental, and vision coverage becomes effective on your date of rehire. However, if your retiree medical coverage under the Retiree Plan immediately preceding your date of rehire was the UnitedHealthcare Medicare Advantage plan or the Kaiser Senior Advantage plan, your coverage under the Medicare Advantage option will end prospectively at the end of the month of your date of hire or as soon as administratively feasible, in accordance with CMS guidelines, as noted above.
- STD, Basic LTD, and Optional LTD coverage becomes effective on your date of rehire.
- If you are not actively at work on the date coverage would normally begin, your effective date for BTA, AD&D, STD, Basic LTD, Optional LTD, Basic Term Life, Optional Term Life Insurance, Spouse/Partner Optional Term Life Insurance, Dependent Term Life Insurance, Critical Illness Insurance (basic and optional), and Accident Insurance coverage is delayed until you return to work (you must return to work in a regular or fixed term position).

The following information regarding the Wells Fargo & Company Retiree Life Insurance Plan (the Retiree Life Insurance Plan) is provided for general information purposes only (and this *Benefits Book* does not constitute part of the Retiree Life Insurance Plan Summary Plan Description). If you are a retiree who has coverage under the Retiree Life Insurance Plan, and you are rehired by Wells Fargo (or any of its subsidiaries or affiliates), your retiree life insurance coverage will continue under the Retiree Life Insurance Plan, subject to applicable plan provisions.

Employment classification changes

Changing from a regular or fixed term employee to an intern or flexible employee

When your employment classification changes from a regular or fixed term employee to an intern or flexible employee and you elect coverage under the Flex HDHP medical plan option (or POS Kaiser – Hawaii, as applicable) during your designated enrollment period, your coverage will begin the first of the month following your employment classification change effective date. For eligible dependents enrolled during your initial designated enrollment period, their coverage begins when your coverage begins.

Changing from an intern or flexible employee to a regular or fixed term employee

When your employment classification changes from an intern or flexible employee to a regular or fixed term employee and you enroll in benefits during your designated enrollment period, coverage for your newly elected medical plan will begin the first of the month following your employment classification change effective date. Coverage for other benefit plans and options begins the first of the month after one full calendar month of service in your regular or fixed term position, except as noted in the "When to enroll — when benefits take effect" section on page 1-15. For eligible dependents enrolled during your initial designated enrollment period, their coverage begins when your coverage begins.

Enrollment election changes

See the "Changing coverage" section starting on page 1-20.

COBRA continuation coverage

Refer to "Appendix E: Continuing Coverage Under COBRA" for information on when coverage becomes effective.

Coordination with other coverage

When you or your dependents have other group medical, dental, or vision coverage (for example, through your spouse's or domestic partner's employer or Medicare), the applicable Wells Fargo-sponsored group health plan and the other plan may both pay a portion of covered expenses. One plan is primary and the other plan is secondary. This is called "coordination of benefits."

Note the following:

- There is no coordination of benefits between benefit plan options under Wells Fargo-sponsored group health plans. Only one benefit option under a Wells Fargo-sponsored group health plan will provide coverage for eligible expenses. For example, you cannot receive benefits under the Health Plan from both a medical plan option and the dental plan option for the same services.
- Wells Fargo medical plan options do not coordinate prescription drug benefits. For example, if you are covered under a Wells Fargo medical plan option and another plan is primary, there is no secondary prescription drug benefit under the Wells Fargo medical plan option.
- See "Chapter 3: Dental Plan" in this *Benefits Book* for information on coordination of benefits under the dental plan benefit option.

- See "Chapter 4: Vision Plan" in this *Benefits Book* for information on coordination of benefits under the vision plan benefit option.

If the applicable Wells Fargo-sponsored group health plan is secondary, it pays only the difference between the other plan's benefit, if lower, and the normal Wells Fargo-sponsored group health plan benefit. When the primary plan pays a benefit that equals or exceeds the normal Wells Fargo-sponsored group health plan benefit for a covered service, the Wells Fargo-sponsored group health plan will not pay any benefit with respect to that covered service.

If you receive benefits from another group health plan that is primary (or a government-supported program other than Medicaid), the primary payer must process your claim before you can submit it to the Wells Fargo-sponsored group health plan.

If you are not covered under Medicare, the following rules determine the order of plan payment under the Wells Fargo-sponsored group health plan:

1. The plan with no coordination of benefits provision is primary.
2. If both plans have a coordination of benefits provision:
   A. The plan covering the person as an employee rather than the plan covering the person as a dependent (or a qualified beneficiary under COBRA) is primary.
   B. For covered persons who have COBRA continuation coverage under a plan, the plan covering the person as a dependent rather than the plan covering the person as a qualified beneficiary under COBRA is primary.
   C. If a person is covered as an employee by two plans, the plan covering the person for the longest period of time is the primary plan.
   D. If a fixed term employee is also covered as a result of full-time employment, the plan offering coverage as a result of full-time employment is primary.
   E. For dependent children covered under each parent's employer's plan, the plan of the parent whose birthday falls earlier in the year is primary.
   F. For children of divorced or separated parents who are covered under each parent's employer's plan, plans pay, unless a court decree stipulates otherwise, in the following order:
      i. The plan of the parent who has custody of the child
      ii. The plan of the spouse or domestic partner of the parent who has custody of the child
      iii. The plan of the parent who does not have custody of the child

If Medicare is the primary payer of claims, these rules apply after Medicare has processed your claim.

If you are still unsure which plan is primary, contact the claims administrator for your Wells Fargo medical plan option. If you receive coverage through an HMO, you may need to contact the HMO directly to determine coordination of benefits.

Coordination with Medicare

This section contains information about how the Wells Fargo & Company Health Plan coordinates with Medicare. Medicare is a separate program administered by the federal government and is not part of the Wells Fargo & Company Health Plan. **You should contact Medicare for questions about enrolling in Medicare and coordination with Medicare, and to determine any consequences and processes applicable to delayed enrollment in Medicare.**

Determining which plan is primary

The coordination of benefits rules applicable to the Wells Fargo & Company Health Plan for individuals eligible for or enrolled in Medicare are established by the Medicare Secondary Payer (MSP) rules adopted by the Centers for Medicare & Medicaid Services. In general, the medical plan coverage under the Wells Fargo & Company Health Plan pays primary for Medicare-eligible employees who are enrolled by virtue of their own or a family member's active employment with Wells Fargo (as determined in accordance with Medicare rules). If you are not covered by virtue of active employment, then the medical plan coverage under the Wells Fargo & Company Health Plan will pay benefits secondary to Medicare to the extent permitted by federal law. Also, if you are not enrolled in Medicare but the Plan would be secondary to Medicare if you were, the Plan will calculate benefits on a secondary basis as though you were enrolled in Medicare. **You should contact Medicare or your medical claims administrator for questions about coordination with Medicare. You should contact Medicare to determine any consequences and processes applicable to delayed enrollment in Medicare.**

Note: There is no coordination of benefits for prescription drug benefit coverage under a self-insured medical plan option of the Wells Fargo & Company Health Plan.

End-Stage Renal Disease (ESRD)

If you or a covered dependent is enrolled in Medicare as a result of ESRD, medical coverage under the Wells Fargo & Company Health Plan will be primary during the 30-month coordination period, to the extent required by federal law. After the 30-month coordination period, Medicare becomes primary and the Plan becomes secondary, to the extent permitted by federal law. If you or your covered dependent is eligible for Medicare as a result of ESRD and does not enroll in Medicare Part A or Part B by the time the 30-month coordination period has ended, the Plan will calculate benefits on a secondary basis as though you are enrolled in Medicare. After the coordination period, when Medicare becomes primary, there is no reduction in the contributions or premiums for medical coverage under the Wells Fargo & Company Health Plan.

Note: There is no coordination of benefits for prescription drug benefit coverage under a self-insured medical plan option of the Wells Fargo & Company Health Plan.

COBRA

If you or your covered dependent is enrolled in Medicare at the time you are receiving COBRA continuation coverage, Medicare is primary and the Plan is secondary, to the extent permitted by federal law. If you are eligible for Medicare but do not enroll in Medicare, the Plan will calculate benefits on a secondary basis as though you are enrolled in Medicare. There is no reduction in the COBRA premiums for the COBRA continuation coverage under the Wells Fargo & Company Health Plan. See "Appendix E: Continuing Coverage Under COBRA" of this booklet for more information on COBRA continuation coverage and how enrollment in Medicare impacts eligibility for COBRA coverage.

Note: There is no coordination of benefits for prescription drug benefit coverage under a self-insured medical plan option of the Wells Fargo & Company Health Plan.

Important information for employees who cover a Medicare-eligible domestic partner

The information in this paragraph is for informational purposes only and does not describe provisions of any Wells Fargo-sponsored group health plan. Medicare may use a different definition of spouse than other federal or state law. If your domestic partner is not considered your spouse for purposes of Medicare and does not enroll in Medicare during their Medicare "Initial Enrollment Period," your domestic partner may be subject to late enrollment penalties or surcharges imposed on late enrollees by Medicare. Medicare late enrollment penalties could apply even if your domestic partner is covered as your dependent under the Wells Fargo & Company Health Plan. When your domestic partner is enrolled in Medicare, generally, Medicare is the primary payer of benefits. **Your domestic partner should contact Medicare for questions about enrolling in Medicare and coordination with Medicare, and to determine any consequences and processes applicable to delayed enrollment in Medicare.**

For more information about Medicare

You can find more information about Medicare on the Medicare website at medicare.gov. **You should also call Medicare at 1-800-633-4227 for more information on enrolling when you or your dependent first become eligible or about any late enrollment penalties or surcharges that may be imposed by the federal government for not enrolling when first eligible for Medicare.**

The information about Medicare eligibility and enrollment in the preceding paragraphs is provided for informational purposes only. The Wells Fargo & Company Health Plan, the plan administrator, Employee Care, and Wells Fargo & Company or any of its subsidiaries or affiliates **cannot** provide any advice to you (or your dependents) regarding eligibility for or enrollment in Medicare. The Wells Fargo & Company Health Plan, the plan administrator, and Wells Fargo & Company or any of its subsidiaries or affiliates will not be responsible if you (or your covered dependents) delay enrollment in Medicare and are subject to late enrollment penalties or surcharges. You will not be entitled to any refund or reduction in contributions or premiums for medical coverage under the Wells Fargo & Company Health Plan if Medicare is the primary payer for benefits provided to you or your covered dependents.

Changing coverage

What changes can you make during the year?

During the plan year, you can change your benefit elections for certain benefit plans and options if one of the following occurs:

- A qualified change in status, also known as a Qualified Event, affects your or your dependents' eligibility under the following plan options (see the "Qualified Events" section starting on page 1-24 for more information):
  - Medical coverage
  - Dental coverage
  - Vision coverage
  - Full-Purpose Health Care Flexible Spending Account
  - Limited Dental/Vision Flexible Spending Account
  - Day Care Flexible Spending Account
  - Legal Services Plan

Note: Interns and flexible employees are only eligible for medical coverage.

- You or your eligible dependent experiences an event that qualifies as a special enrollment right (see the "Special enrollment rights" section starting on page 1-23 for more information).
  - Medical coverage only
- Any event or reason (regular and fixed term employees only)
  - Optional Term Life
  - Spouse/Domestic Partner Term Life
  - Dependent Term Life
  - Optional LTD

  Regular and fixed term employees, see "Chapter 7: Life Insurance Plan" and "Chapter 12: Long-Term Disability Plan" in this *Benefits Book* for more information.

If you enroll a dependent (including your spouse or domestic partner) when you change your benefit elections, you are certifying that your dependent meets the stated dependent eligibility requirements (see the "Eligible dependents" section starting on page 1-6).

Regular and fixed term employees can drop AD&D coverage, Optional Critical Illness Insurance coverage, and Optional Accident Insurance coverage during the year for any reason by calling Employee Care. You can also decrease AD&D coverage during the year for any reason by calling Employee Care. Dependents can only be dropped mid-year from Optional Critical Illness Insurance coverage and Optional Accident Insurance coverage if they lose eligibility. If you want to make other changes to these plans, you have to wait until Annual Benefits Enrollment (see the "Annual Benefits Enrollment" table starting on page 1-21 for more information). (There are limited circumstances when newly eligible dependents may be automatically added to Optional Critical Illness and Optional Accident Insurance. See the certificate of insurance for more information.)

If you have questions about changing or adding coverage, call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

If your coverage is COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA" for contact information.

How to Enroll — Changing Coverage

To change coverage due to a Qualified Event or Special Enrollment Right, you will need to go to Workday and type Change Benefits in the search bar. Choose from the appropriate event in the Change Reason drop down menu. Complete and save each benefit plan enrollment elections or changes you would like to make. **Important:** Changes are not submitted until you select "I Accept" in the Review and Sign step. Once you click on "I Accept", the enrollment will be forwarded to HR for approval, if required.

If you have questions about changing or adding coverage or do not have access to Workday, call Employee Care at 1-877-HRWELLS (1-877-479-3557). option 2.

Enrolling a newborn or newly adopted child

A newborn or newly adopted child can be added to your benefits by submitting an election online in Workday within 60 days of your child's birth, adoption, or placement for adoption. See the "How to Enroll — Changing Coverage" section above for more information. (If your coverage is COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA" for contact information.) Do not call the claims administrator or insurer for your benefit option directly to enroll your new child. If you are unable to make the election using Workday, you may call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2 to add your child to your benefits. You must make the election in Workday or by calling Employee Care within 60 days of your child's birth, adoption, or placement for adoption or you will not be allowed to enroll your child until the next Annual Benefits Enrollment, or a new Qualified Event or special enrollment event occurs. Medical coverage (including Health Savings Account eligibility, if applicable) will be effective as of the date of birth, adoption, or placement for adoption. However, enrollment in any other benefit plans or corresponding benefit options due to a Qualified Event of birth or adoption of a child will be effective the later of the following:

- The first of the month following the date of the event
- The first of the month following the date you submit the elections in Workday
- The first of the month following the date you call Employee Care to make your elections

For additional information, see the Qualified Event for "Birth or adoption of a child" on page 1-28.

After you make an election change to add your child, you may not make any other changes to that benefit election during the 60-day period, unless you experience another Qualified Event or special enrollment event.

Note: If you drop your (or your dependents') Wells Fargo-sponsored medical coverage due to the Qualified Event for birth, adoption, or placement for adoption and you (or your dependents) are being added to another employee's Wells Fargo-sponsored medical coverage due to the same event, the medical coverage with you as the subscriber (and any dependents you cover) will end on the date immediately before the date of birth, adoption, or placement for adoption. For example, you are enrolled in medical coverage and cover yourself and one child; your spouse is also an employee with medical coverage for themself only. You and your spouse have another baby whose birthdate is January 23. As a result of the birth of the child, your spouse enrolls the new baby and adds you and the other child to their Wells Fargo medical coverage at the you + spouse + children coverage level within 60 days of the date of birth of the baby. Coverage for you and the two children added to your spouse's medical coverage at Wells Fargo becomes effective January 23 (the date of birth of the baby). As a result of the birth of the child, you also drop coverage for you and the one child previously covered under your enrollment. The date your coverage ends as an employee covering one child is January 22.

If you are a regular or fixed term employee, you may also add dependent term life insurance coverage at any time throughout the year without providing a statement of health. See the "Life Insurance Plan" chapter in this *Benefits Book* for more information.

Covered employee becomes enrolled as a dependent of another employee

Regardless of your employment classification, you may not be covered as both an employee and a spouse or domestic partner of another employee, or an employee and a dependent child of another employee, at the same time (except for coverage under the Life Insurance Plan and AD&D Plan).

Annual Benefits Enrollment

During Annual Benefits Enrollment, you receive information about your benefit plans and options and instructions for making changes to your benefit elections for the next plan year. Generally, you may enroll in or drop coverage for yourself or your dependents during Annual Benefits Enrollment. To enroll eligible dependents, you must also be enrolled in the applicable benefit option.

If you are a regular or fixed term employee, you may also be able to increase your life insurance coverage if you are approved under the applicable statement of health process. See "Chapter 7: Life Insurance Plan" in this *Benefits Book* for more information.

If you do not make changes during Annual Benefits Enrollment, your enrollment in the benefit plans and benefit options for which you are eligible will generally continue at the same coverage level, unless:

- The plan is terminated
- The plan or benefit option is no longer available in your location
- The benefit option is no longer offered under the plan

- You are no longer eligible
- You fail to make a timely full payment for coverage
- You do not provide certification or proof of your dependents' eligibility when requested

Regular and fixed term employees must make a new election each plan year to contribute to the Full-Purpose Health Care Flexible Spending Account, the Limited Dental/Vision Flexible Spending Account, the Day Care Flexible Spending Account, or the health savings account, even if you want the same contribution amount for the next year.

If you don't receive your Annual Benefits Enrollment information by November 1, call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

Note: If your coverage is COBRA continuation coverage and you do not receive your Annual Benefits Enrollment information, call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272).

Effective date

Changes made during Annual Benefits Enrollment and the corresponding cost for coverage generally go into effect on January 1 of the following plan year, subject to any actively-at-work requirements, confinement requirements, or other delayed effective date provisions disclosed in the applicable chapters of this *Benefits Book*.

If you move

If you're planning to move (changing your permanent residential address), update your address online in Workday as soon as you know your new address. If you do not have access to Workday, you may call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to speak with a representative to update your address. If your coverage is COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA" for information on updating your address.

A move may impact your medical plan benefit options and result in one of the following:

- Depending on where you move, you may change your medical plan benefit option if a new medical plan benefit option is available in your new area (based on your home address ZIP code).
- Depending on where you move, your current medical plan benefit option may no longer be available to you; in this case your medical plan benefit option must be changed to one that is available in your new area (based on your home address ZIP code) or you may voluntarily elect to drop your medical coverage (medical coverage for any enrolled dependents will also be dropped). If your change in permanent residence is outside the 50 states within the United States, you are no longer eligible to be enrolled in a medical benefit option and your medical coverage will automatically be dropped. However, if your change in permanent residence is outside the 50 states within the United States and you are on international assignment, you may be eligible for the Wells Fargo & Company International Plan (see the "Additional requirements for the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance" section on page 1-6).
- If your covered spouse or dependent moves, making them ineligible for coverage under your current medical plan benefit option, you may drop the individual from your medical coverage or change medical plans to another medical plan benefit option that is available to you (based on your home address ZIP code) that provides for coverage in the area where your spouse or dependent has moved.

In order to ensure that you receive benefit plan communications in a timely manner, it is your responsibility to ensure that your current address is on file.

You have 60 days after the date of the move to request a change to your medical plan benefit option, if applicable. You will need to update the change of address in Workday. Once the address change is updated if your medical plan is no longer available in your new location, you will need to call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days from the date of the move to make any changes to your medical plan. If your current medical plan is no longer available due to the address change, and you do not contact Employee Care within 60 days of the move, you will be manually enrolled in the Copay Plan with HRA at your existing level of coverage. However, if you were enrolled in a High-Deductible Health Plan (HDHP) — Kaiser medical plan or the Narrow Network Plan with HSA medical plan, and that plan is not available in your new location, and you do nothing in Workday, you will be manually enrolled in the Higher Use Plan with HSA at your existing level of coverage. If your change in permanent residence is outside the 50 states within the United States, you are no longer eligible to be enrolled in a medical benefit option and your medical coverage will be dropped. However, if your change in permanent residence is outside the United States and you are on international assignment, you may be eligible for the Wells Fargo & Company International Plan (see the "Additional requirements for the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance" section on page 1-6).

Effective date

Any changes made as a result of a change in your permanent residential address and the corresponding cost for coverage will be effective the first of the month following the date of the move, or the first of the month following the date you call Employee Care, whichever is later. If you add or drop dependents based on the move, the changes will be effective the first of the month following the move, or the first of the month following the date you call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to make changes to your medical plan if applicable, within 60 days of your permanent residential address change. If the date of your move is the first of the month and you make the change in Workday up to 30 days before the date of your move, the coverage effective date will be the date of your move. For example, if you are moving on August 1, and you make the change in Workday or call Employee Care on July 25 and request to change your medical plan benefit option, the effective date of your new medical plan benefit option will be August 1, and your cost for coverage will be adjusted accordingly.

Special enrollment rights

General information

The Health Insurance Portability and Accountability Act of 1996 and the Children's Health Insurance Program Reauthorization Act of 2009 provide special enrollment rights for medical plan coverage if you decline Wells Fargo-sponsored medical coverage for yourself or your dependents during your designated enrollment period or during Annual Benefits Enrollment because of other medical coverage that is in effect. Special enrollment rights only apply if the individual was actually enrolled in other medical coverage.

For example, if your spouse or domestic partner loses other medical coverage due to a termination of your spouse's or domestic partner's health coverage through their employer resulting from a loss of eligibility, you may enroll your spouse or domestic partner in a medical plan benefit option under the Wells Fargo & Company Health Plan (or the Wells Fargo & Company International Plan, if applicable) for which you are eligible. However, special enrollment rights do not allow you to make an election to enroll in any other benefit plan or benefit option.

Special enrollment events

Make your enrollment election online in Workday to enroll yourself and any of your eligible dependents (see the "Eligible dependents" section starting on page 1-6) in an available medical plan benefit option if you experience one of the following special enrollment events:

- You were eligible for but had originally declined Wells Fargo-sponsored medical coverage because of enrollment in other medical coverage, but that other coverage has now been lost. Loss of eligibility under these special enrollment rights does not include a loss caused due to the failure of the employee or dependent to pay premiums on a timely basis, or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan), or due to voluntarily dropping coverage. Loss of eligibility for coverage under special enrollment rights includes (but is not limited to):
  - Loss of eligibility for other medical coverage, including an individual insurance policy, due to:
    - Divorce, legal separation, or annulment
    - Cessation of dependent status (such as reaching the maximum age to be eligible as a dependent child under the other coverage)
    - Death of an employee (the employee must be your spouse, domestic partner, or eligible child)
    - Termination or reduction in hours of employment
    - The other coverage is no longer offered to any class of similarly situated individuals
    - Benefits are not provided under the other coverage for any individual who is outside the service area of that plan (and if the other coverage is group coverage, no other benefit option is available under that group's benefit package)
  - Termination of your spouse's or dependents' (including a domestic partner's or their eligible children's) health coverage through their employer due to:
    - Loss of eligibility
    - The employer stopped making contributions toward other coverage (this does not include COBRA coverage)
  - End of the full 18-, 29-, or 36-month COBRA coverage continuation period
- You marry, or you or your spouse gives birth or adopts a child, or a child is placed with you for adoption
- You, your spouse, or your dependent (including a domestic partner or their children) loses eligibility for coverage for Medicaid or a state Child Health Insurance Program (CHIP)
- You, your spouse, or your dependent (including a domestic partner or their children) becomes eligible for premium assistance under Medicaid or CHIP

Note: Special enrollment rights do not apply if other medical coverage is lost because of a failure of the employee or dependent to pay premiums on a timely basis, or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan), or due to voluntarily dropping coverage.

Special enrollment timing

You must enroll in or add eligible dependents to medical coverage within 60 days of the date of the special enrollment event by making your election online in Workday. If you are unable to make the election using Workday, you may call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2 to enroll or add eligible dependents to your benefits within 60 days of the date of the special enrollment event. If your coverage is COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA" for information on changing your benefit elections due to a special enrollment event. See the "Changing coverage" section starting on page 1-20 for more information.

You may also make your enrollment election online in Workday up to 30 days before you experience an event that qualifies as a special enrollment right (for example, loss of eligibility for other medical coverage) to enroll in or add eligible dependents to medical coverage.

After the 60-day enrollment period expires, you cannot enroll in or add new dependents to medical coverage. Unless you or your eligible dependents experience a Qualified Event or an event resulting in a special enrollment right, you will be required to wait until the next Annual Benefits Enrollment period to enroll in or add your dependents to coverage.

After you make an election or change due to a special enrollment right, you may not make further changes to that benefit election during the 60-day enrollment period unless you experience another special enrollment event or Qualified Event.

Effective date

Coverage, as a result of special enrollment rights, and the corresponding cost for coverage will generally be effective the first of the month following the date of the event or the first of the month following the date you enroll, whichever is later (as long as you have provided any required information or documentation, as applicable). The only change that will be made retroactive to the event date is your enrollment in or the addition of dependents to medical coverage due to the birth, adoption, or placement for adoption of an eligible child.

Qualified Events

There are certain qualifying status change events, called "Qualified Events," that allow you to make changes to your benefit elections.

Regular and fixed term employees may make a change to the following benefit plan options:

- Medical
- Dental
- Vision
- Legal Services Plan
- Full-Purpose Health Care Flexible Spending Account or Limited Dental/Vision Flexible Spending Account
- Day Care Flexible Spending Account

Interns and flexible employees may make only a change to their medical benefit plan option.

A Qualified Event is an event listed in the "Qualified Events" table starting on page 1-26 that results in gain or loss of eligibility for coverage by you, your spouse or domestic partner, or your dependents. When you make changes to your benefit elections as a result of a Qualified Event, your changes must be consistent with the corresponding event and generally impact the same type of coverage. This means that the coverage provides the same type of benefits at Wells Fargo as the benefit coverage lost or gained under the other group plan. For example, you cannot cancel medical coverage for an individual who has become eligible for coverage under another plan unless that individual actually becomes covered under the other medical plan. The table describes the eligible Qualified Events and the permitted election changes that are consistent with each Qualified Event. The plan administrator has sole discretion to determine whether a requested change is a result of and corresponds to a Qualified Event.

To change your benefit elections, you must make your new elections within 60 days of the date of the applicable event listed in the "Qualified Events" table starting on page 1-26. If your coverage is COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA" for information on changing your benefit elections due to a Qualified Event listed in this chapter.

How to change your benefit elections due to a Qualified Event

Use Workday to make your new benefit elections within 60 days of the date of the applicable Qualified Event for the following:

- Marriage or formation of domestic partnership (including marrying your domestic partner)
- Divorce, annulment, legal separation, termination of domestic partnership, or death of spouse or domestic partner
- Birth or adoption of a child
- Change in employment status for your spouse, domestic partner, or dependent child that impacts eligibility for benefits through the other employer
- Open enrollment under your spouse's, domestic partner's, or dependent child's employer's plan
- Change in day care services or needs
- Medicare, Medicaid, or CHIP entitlement
- New eligibility for Medicaid or CHIP subsidy
- Medicare loss of eligibility
- Medicaid or CHIP loss of eligibility

If you are unable to make the election using Workday, you may call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to make your election changes.

You must call Employee Care to make any election changes due to a judgment, decree, or order that requires an employee to provide coverage for a dependent child or if a judgment, decree, or order required that another individual provide coverage for one of your covered dependents.

See the "Changing coverage" section on page 1-20 for more information.

You have up to 30 days before the date of certain Qualified Events (for example, marriage) to make a change to your benefit elections. If the future event does not take place as expected, you must call Employee Care to cancel your benefit election change.

Additional important information

- After you make an election change due to a Qualified Event, you may not make any other changes to that benefit election during the 60-day period, unless you experience another Qualified Event or special enrollment event.
- If the change in your benefit elections is the result of a change in your marital or relationship status, it is your responsibility to understand your status as it relates to your state's laws. For example, if you are requesting a change in your benefit elections due to legal separation, it is your responsibility to know whether the separation from your spouse is an actual legal separation based on your state's laws.
- If the change in your benefit elections results in enrolling a dependent (including your spouse or domestic partner), by enrolling that dependent, you are certifying that your dependent meets the stated eligibility requirements; see the "Eligible dependents" section starting on page 1-6.

- If you currently cover a domestic partner or their children and you legally marry your current domestic partner, you are now eligible to pay for certain coverage (medical, dental, vision) on a before-tax basis. To take advantage of before-tax elections, you must make your election changes within 60 days of the date of marriage. If you fail to make before-tax elections within the 60 days, your next opportunity to make before-tax elections is the next Annual Benefits Enrollment period or when you experience another special enrollment event or a Qualified Event. Changes to benefit elections for domestic partners and their children can only be made for situations described in the "Qualified Events" table starting on page 1-26.

Effective date

If you make a change to your benefit elections within the permitted 60-day period as a result of a Qualified Event, most changes in coverage and corresponding cost for coverage will be effective the first of the month following the date of the event or the first of the month following the date you make your election changes online in Workday or you call Employee Care, whichever is later. In general, the change in premium is effective on the date of change in coverage. The following are exceptions to the effective date of coverage changes and the corresponding cost for coverage described above:

- If you are a new hire, rehire, or become newly eligible for different benefit plan options as a result of an employment classification change, see the "When to enroll — when benefits take effect" section on page 1-15.
- If you enroll in a medical plan benefit option (or change your medical plan benefit option) or add eligible dependents to your medical plan due to birth, adoption, or placement for adoption of an eligible child, the effective date of coverage will be retroactive to the date of birth, adoption, or placement for adoption. This applies to medical coverage only. For example, if you have a baby on June 10 and on July 25 you make your election in Workday to add your new child to your existing medical coverage, the effective date of your child's medical coverage will be June 10. (You are responsible for paying your share of the cost of coverage for the retroactive period.) **Note:** In this example, if you are eligible for and add your child to your dental and vision coverage, your child's coverage effective date for those plans will be the first of the month following the date you made the election to add your child.
- If the event date is the first of the month and you make the election up to 30 days before the event date, the coverage effective date will be the event date. For example, if you get married on August 1 and you make the election on July 25 to add your new spouse to your existing medical coverage, the effective date of your new spouse's medical coverage will be August 1, and your cost for coverage will be adjusted accordingly.
- Termination of coverage due to the death of a spouse, domestic partner, or other eligible dependent is effective on the date of death.
- Except in cases of misrepresentation or fraud, termination of coverage due to a dependent's loss of eligibility is effective at the end of the month in which you make the change in Workday or notify Employee Care that the dependent is ineligible. For potential consequences related to misrepresentation or fraud, see the "Consequences of fraudulent enrollment" section on page 1-9.

Marriage or formation of domestic partnership — change in the number of the employee's eligible dependents	
What benefit election changes can you make when you get married or form a domestic partnership?	
Medical, Dental, or Vision **Note:** Interns and flexible employees are only eligible for medical coverage.	**You may enroll or add:** • Yourself, if you get married • Your newly eligible spouse or domestic partner • Newly eligible dependent children of your new spouse or domestic partner • Previously eligible dependent children ***only if*** you enroll your newly eligible spouse or their newly eligible dependent children ***Reminder: If you want to enroll your new spouse or eligible dependent children, you must also enroll or be enrolled. If you want to enroll your new domestic partner or their children, you must already be enrolled.*** **You may drop:** • Your existing coverage ***only if*** you enroll in the same type of coverage under your new spouse's employer's plan (excluding domestic partnerships) • Your covered dependent children ***only if*** they enroll in the same type of coverage under your new spouse's employer's plan • Your covered dependent children who are the biological or adopted children of both you and your domestic partner ***only if*** they enroll in the same type of coverage under your domestic partner's employer's plan • Your covered former domestic partner, who is now your new spouse, ***only if*** they enroll in the same type of coverage under your new spouse's employer's plan ***Reminder: If you elect to drop your coverage, coverage for any enrolled dependents, including your spouse or domestic partner, will also be dropped.*** **Regular and fixed term employees may change medical plans if:** • You add your newly eligible spouse or their newly eligible dependent children to Wells Fargo-sponsored medical coverage • You add your new domestic partner to your Wells Fargo-sponsored medical coverage ***only if*** your new domestic partner qualifies, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment of premiums for federal income tax purposes
Full-Purpose Health Care FSA* and Limited Dental/Vision FSA*	**Regular and fixed term employees may:** • Enroll or increase your FSA election for your newly eligible spouse or newly eligible dependent children • Decrease your FSA election if you or your dependent children enroll in your new spouse's employer's medical plan **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA*	**You must** drop your FSA election if your newly eligible spouse is not employed outside the home, unless your new spouse is seeking employment, enrolled as a full-time student, or mentally or physically incapable of self-care. **Regular and fixed term employees may:** • Enroll or increase your FSA election for newly eligible dependent children • Drop or decrease your election if your newly eligible spouse makes contributions to a day care (or dependent care) FSA under their employer's plan
Legal Services	**Regular and fixed term employees may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

* You may not make changes to your flexible spending account (FSA) elections as a result of the formation of a domestic partnership unless your domestic partner qualifies, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment for federal income tax purposes.

Divorce, annulment, legal separation, termination of domestic partnership, death of spouse or domestic partner — change in the number of the employee's eligible dependents

What benefit election changes can you make when you get a divorce, annulment, or legal separation; terminate your domestic partnership; or your spouse or domestic partner dies?

***Note:** It is your responsibility to understand your status as it relates to your state's laws. For example, if you are requesting a change in your benefit elections due to legal separation, it is your responsibility to know whether the separation from your spouse is an actual legal separation based on your state's laws.*

Medical, Dental, or Vision **Note:** Interns and flexible employees are only eligible for medical coverage.	**You must** drop your former spouse or former domestic partner and, unless a court or other appropriate government entity issues a qualified medical child support order (QMCSO) requiring you to maintain coverage, any dependents of your former spouse or domestic partner who are not also your dependents. **You may enroll or add:** • Yourself if you lose the same type of coverage under your former spouse's or domestic partner's employer's plan • Your eligible dependent children if they lose the same type of coverage under your former spouse's or domestic partner's employer's plan • Your previously eligible dependent children only if you newly enroll yourself or you enroll an eligible dependent child who lost the same type of coverage under your former spouse's or domestic partner's employer's plan ***Reminder: If you want to enroll your eligible dependent children, you must also enroll or be enrolled.*** **You may not drop** coverage for yourself or other covered eligible dependents. **Regular and fixed term employees may change benefit options if** you add coverage for your eligible dependent children.
Full-Purpose Health Care FSA* and Limited Dental/ Vision FSA*	**Regular and fixed term employees may:** • Enroll or increase your FSA election when coverage is lost under your former spouse's employer's medical plan • Drop or decrease your FSA election **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA*	**Regular and fixed term employees may:** • Enroll or increase your FSA election for eligible dependents. For example, if your spouse's death results in new day care expenses for your eligible dependents. • Drop your FSA election if dependent eligibility is lost. For example, if your dependent now resides with your ex-spouse, you may stop contributing.
Legal Services	**Regular and fixed term employees may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

* You may not make changes to your flexible spending account (FSA) elections as a result of the termination of a domestic partnership unless your domestic partner qualified, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment for federal income tax purposes.

Birth or adoption of a child — change in the number of the employee's eligible dependents

What benefit election changes can you make when you, your spouse, or your domestic partner has a baby or adopts a child (including placement for adoption)? This event also includes when you, your spouse, or domestic partner becomes the newly appointed legal guardian, legal custodian, or foster parent for a child (see the "Legal guardian, legal custodian, and foster children" section on page 1-8 for more information), or if you or your spouse or domestic partner has been newly identified as the parent of a child.

Medical, Dental, or Vision

Note: Interns and flexible employees are only eligible for medical coverage.

You may enroll or add:

- Yourself if you are the biological or adopting parent
- Your spouse (for situations where the employee and spouse are the birth or adopting parents)
- Your spouse ***only if*** you add your newly eligible child (for situations where the employee or spouse are the newly appointed legal guardian, legal custodian, or foster parent)
- The newly eligible child
- Your previously eligible dependent children ***only if*** you newly enroll yourself, or add your spouse or the newly eligible child
- Your domestic partner or your domestic partner's eligible dependent children ***if*** you add your newly eligible child (for situations where the employee and the domestic partner are the biological or adoptive parents)
- Your domestic partner or your domestic partner's eligible dependent children ***if*** you add your newly eligible child to your existing coverage (for situations where the employee is the newly appointed legal guardian, legal custodian, or foster parent)
- Your domestic partner or your domestic partner's eligible dependent children ***if*** you add the domestic partner's newly eligible child to your existing coverage (for situations where the domestic partner is the biological or adoptive parent, or the newly appointed legal guardian, legal custodian, or foster parent)

Reminder: If you want to enroll your newly eligible child, spouse or domestic partner, or other eligible dependent children, you must also enroll or be enrolled.

You may drop:

- Yourself ***only if*** you enroll in the same type of coverage under your spouse's employer's plan (excludes domestic partnerships)
- Your spouse or your covered dependent children ***only if*** they enroll in the same type of coverage under your spouse's employer's plan (excludes domestic partnerships)
- Your covered dependent children who are also your domestic partner's children, if they enroll in the same type of coverage under your domestic partner's employer's plan
- Your domestic partner's or their child's existing coverage if they enroll in the same type of coverage under your domestic partner's employer's plan

Reminder: If you elect to drop your coverage, coverage for any enrolled dependents, including your spouse or domestic partner, will also be dropped.

Regular and fixed term employees may change benefit options if:

- You enroll or add coverage for your newly eligible child or your spouse (for situations where the employee or the spouse is the biological or adoptive parent)
- You add your domestic partner or your domestic partner's newly eligible child to your medical coverage ***only if*** your domestic partner or your domestic partner's newly eligible child qualifies, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment of premiums for federal income tax purposes

Continued on the next page.

Full-Purpose Health Care FSA* and Limited Dental/ Vision FSA*	**Regular and fixed term employees may:** • Enroll or increase your FSA election • Drop or decrease your FSA election if you enroll with like medical coverage under your spouse's employer's plan **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA*	**Regular and fixed term employees may** enroll or increase your FSA election.
Legal Services	**Regular and fixed term employees may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

* You may not make changes to your flexible spending account (FSA) elections if your domestic partner adopts a child and the child is not also your biological or adopted child.

Loss of dependent eligibility for coverage under your Wells Fargo employer sponsored plan	
What benefit election changes can you make when your dependent no longer meets the Wells Fargo dependent eligibility requirements (for example, when your dependent child reaches maximum age, your dependent child dies, or your child is placed for adoption outside of your home)?	
Medical, Dental, or Vision **Note:** Interns and flexible employees are only eligible for medical coverage.	**You must** drop coverage only for the dependent who loses eligibility. ***Reminder: You may not drop coverage for yourself or any other enrolled dependents.*** **You may not** change benefit options with this event.
Full-Purpose Health Care FSA* and Limited Dental/ Vision FSA*	**Regular and fixed term employees may** drop or decrease your FSA election. **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA*	**Regular and fixed term employees may** drop or decrease your FSA election ***only if*** your qualified day care expenses become ineligible for reimbursement due to loss of dependent eligibility. If this was the only eligible dependent covered, you must stop contributions.
Legal Services	**Regular and fixed term employees may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

* You may not make changes to your flexible spending account (FSA) elections if your domestic partner or their children become ineligible unless they qualify, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment for federal income tax purposes.

Change in employment status for you that affects eligibility for your benefits at Wells Fargo[1,2]	
What benefit election changes can you make when you have a change in your employment status (or classification) that affects your eligibility for benefits at Wells Fargo?	
Medical, Dental, or Vision **Note:** Interns and flexible employees are only eligible for medical coverage.	**If you become eligible for different benefit plan options as a result of an employment classification change (for example, your employment classification changes from an intern or flexible employee to a regular or fixed term employee or vice versa), you may enroll:** • Yourself • Your spouse or domestic partner • Your eligible dependent children ***Reminder: If you want to enroll your spouse or domestic partner or other eligible dependent children, you must also enroll.*** **Automatic drop:** If a change in your employment classification makes you ineligible for certain benefits (for example, your employment classification changes from a regular or fixed term employee to an intern or flexible employee or vice versa), your coverage (and that of any enrolled dependents, including your spouse or domestic partner) will be dropped automatically for the benefit options for which you are no longer eligible. You may have the right to elect continuation coverage under COBRA for you, your spouse, and your eligible dependents for the coverage lost. See "Appendix E: Continuing Coverage Under COBRA" for more information. **Leave of absence:** If you take a leave of absence, generally, you may not make changes to your benefit elections. See "Appendix D: Leaves of Absence and Your Benefits" for more information.
Full-Purpose Health Care FSA and Limited Dental/ Vision FSA	**If your employment classification changes from an intern or flexible employee to a regular or fixed term employee, you are newly eligible for this benefit and may enroll.** **Automatic drop:** If your employment classification changes from a regular or fixed term employee to an intern or flexible employee, you are no longer eligible for this benefit and your FSA election will be dropped automatically. **Leave of absence:** If you take a leave of absence, generally, you may not make changes to your benefit elections. See "Appendix D: Leaves of Absence and Your Benefits" for more information. **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA	**If your employment classification changes from an intern or flexible employee to a regular or fixed term employee, you are newly eligible for this benefit and may enroll.** **Automatic drop:** If your employment classification changes from a regular or fixed term employee to an intern or flexible employee, you are no longer eligible for this benefit and your FSA election will be dropped automatically. **Leave of absence:** If you take a leave of absence or return from a leave of absence, generally, you may not make changes to your benefit elections. See "Appendix D: Leaves of Absence and Your Benefits" for more information. However, if your day care needs change as a result of taking or returning from a leave of absence, see the "Change in day care services or needs" table on page 1-38 of this Qualified Events table for information on allowed election changes.
Legal Services	**Regular and fixed term employees may** enroll, increase, decrease, or drop coverage. **Automatic drop:** If your employment classification changes from a regular or fixed term employee to an intern or flexible employee, you are no longer eligible for this benefit and your coverage will be dropped automatically.

Continued on the next page.

Life Insurance, AD&D, and Disability Plans	**If your employment classification changes from an intern or flexible employee to a regular or fixed term employee, you are newly eligible for these benefits and may enroll:** • Yourself • Your spouse or domestic partner (Life Insurance and AD&D coverage only) • Your eligible dependent children (Life Insurance and AD&D coverage only) ***Reminder: To enroll your spouse or domestic partner or eligible dependent children in AD&D coverage, you must also enroll.*** **Automatic drop:** If your employment classification changes from a regular or fixed term employee to an intern or flexible employee, you are no longer eligible for these benefits and your coverage (and that of any enrolled dependents, including your spouse) will be dropped automatically. You may be able to convert your group coverage to an individual policy for certain coverage types. For more information, see the applicable chapter in this *Benefits Book*. **Leave of absence:** If you take a leave of absence, generally, you may not make changes to your benefit elections. See "Appendix D: Leaves of Absence and Your Benefits" for more information.
Optional Critical Illness Insurance and Optional Accident Insurance Plans	**If your employment classification changes from an intern or flexible employee to a regular or fixed term employee, you are newly eligible for these benefits and may enroll:** **Automatic drop:** If your employment classification changes from a regular or fixed term employee to an intern or flexible employee, you are no longer eligible for these benefits and your coverage (and that of any enrolled dependents, including your spouse) will be dropped automatically. For more information, see the applicable chapter in this *Benefits Book*. **Leave of absence:** If you take a leave of absence, generally, you may not make changes to your benefit elections. See "Appendix D: Leaves of Absence and Your Benefits" for more information.

1. Change in employment status means your Wells Fargo employment classification changes. See the "Eligible employees" section on page 1-5 for more information about employment classifications.

2. Having an employment classification change from regular to fixed term or vice versa, receiving a promotion or salary increase, or having a job class change does not impact eligibility for benefits and no changes to your benefit elections are allowed for these employment status changes.

Change in employment status due to obtaining new employment outside of Wells Fargo while receiving Wells Fargo severance pay	
What benefit election changes can you make when you **obtain new** employment outside of Wells Fargo while receiving Wells Fargo severance pay?	
Medical, Dental, or Vision	**You may** drop coverage for yourself and your dependents (including your spouse or domestic partner) if you become enrolled in the same type of coverage through your new employer's plan. **Reminder: If you elect to drop your coverage, coverage for any enrolled dependents, including your spouse or domestic partner, will also be dropped.**
Full-Purpose Health Care FSA and Limited Dental/Vision FSA	**You may** drop or decrease your FSA election if you become enrolled in coverage under your new employer's medical plan. **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA	NA – Day Care FSA coverage does not continue if you are receiving Wells Fargo severance pay
Legal Services	**You may** drop coverage. **Reminder: If you elect to drop your coverage and you are enrolled in family coverage, coverage for any enrolled dependents, including your spouse or domestic partner, will also be dropped.**
Life Insurance, AD&D, Optional Critical Illness Insurance, and Optional Accident Insurance	**You may** drop coverage.
Disability Plans	NA – Disability coverage does not continue if you are receiving Wells Fargo severance pay
Note: For the changes permitted above, once you drop coverage, you may not reenroll unless you experience another applicable Qualified Event or special enrollment right event or at Annual Benefits Enrollment as applicable.	

Change in employment status for your spouse or domestic partner or dependent child that affects eligibility (becoming newly eligible for benefits through their employer's plan)

What benefit election changes can you make when your spouse or domestic partner or dependent child gets a new job (or has a change in employment status) that makes you, your spouse or domestic partner, or your dependent child eligible for coverage through that person's employer's plan?

Medical, Dental, or Vision **Note:** Interns and flexible employees are only eligible for medical coverage.	**You may drop:** • Coverage for yourself if you become enrolled in the same type of coverage through your spouse's employer's plan • Coverage for yourself if you become enrolled in the same type of coverage through your domestic partner's employer's plan, but only if your domestic partner qualifies, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment of premiums for federal income tax purposes • Coverage for your spouse or domestic partner if they become enrolled in the same type of coverage through their employer's plan • Coverage for covered dependent children if they become enrolled in the same type of coverage through their own employer's plan or your spouse's employer's plan • Coverage for your domestic partner's children if they become enrolled in the same type of coverage through their own employer's plan or your domestic partner's employer's plan ***Reminder: If you elect to drop your coverage, coverage for any enrolled dependents, including your spouse or domestic partner, will also be dropped.*** **You may not drop coverage for yourself if:** • Your dependent child gets a new job or has a change in employment status • Your domestic partner gets a new job or has a change in employment status and your domestic partner does not qualify, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment of premiums for federal income tax purposes **You may not** change benefit options with this event.
Full-Purpose Health Care FSA* and Limited Dental/ Vision FSA*	**Regular and fixed term employees may** drop or decrease your FSA election if you become enrolled in coverage under your spouse's employer's medical plan. **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA*	**Regular and fixed term employees may:** • Enroll or increase your contributions if your spouse begins new employment and has not previously been employed • Drop or decrease your FSA election if your spouse begins new employment and enrolls in their employer's day care FSA (dependent care FSA)
Legal Services	**Regular and fixed term employees may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

* You may not make changes to your flexible spending account (FSA) elections if you, your domestic partner, or any dependent children enroll in your domestic partner's employer's plan unless your domestic partner qualifies, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment for federal income tax purposes.

Change in employment status for your spouse or domestic partner or dependent child that affects eligibility (becoming ineligible for benefits through their employer's plan as a result of termination or other change in employment status)	
What benefit election changes can you make when employment is terminated for your spouse or domestic partner or dependent child (or they have a change in employment status), resulting in a loss of eligibility under their employer's plan?	
Medical, Dental, or Vision **Note:** Interns and flexible employees are only eligible for medical coverage.	**You may enroll or add:** • Yourself if you or your dependent has lost the same type of coverage under another employer's plan • Your spouse or domestic partner who has lost the same type of coverage under another employer's plan, or if you newly enroll yourself or other dependents who have lost the same type of coverage under another employer's plan • Your eligible dependent children who have lost the same type of coverage under another employer's plan, or if you newly enroll yourself or your spouse who has lost the same type of coverage • Your other eligible dependent children ***only if*** you enroll or add coverage for your eligible dependent who has lost the same type of coverage under another employer's plan ***Reminder: If you want to enroll your spouse, domestic partner, or eligible dependent children, you must also enroll or be enrolled.*** **You may not** drop coverage for yourself, your spouse or domestic partner, or your eligible dependent children. **You may** change plans if you add coverage for your spouse or domestic partner or your eligible dependent children.
Full-Purpose Health Care FSA* and Limited Dental/ Vision FSA*	**Regular and fixed term employees may** enroll or increase your election if you lost coverage under your spouse's employer's medical plan. **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA*	**Regular and fixed term employees may:** • Enroll or increase your FSA election if your spouse loses eligibility under their employer's day care FSA (dependent care FSA) but continues to be employed. • Enroll or increase your contributions if your spouse loses eligibility under their employer's day care FSA (dependent care FSA) due to loss of employment. If your spouse is not employed, then they need to meet one of the other criteria detailed in "Chapter 6: Day Care Flexible Spending Account." • Drop or decrease your FSA election if eligibility is lost; for example, if your spouse is no longer employed and will be caring for your dependent children.
Legal Services	**Regular and fixed term employees may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

* You may not make changes to your flexible spending account (FSA) elections as a result of the change in employment status or termination of employment for your domestic partner or their children unless they qualify, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment for federal income tax purposes.

Open enrollment under your spouse's, domestic partner's, or dependent child's employer's plan	
What benefit election changes can you make when your spouse or domestic partner or dependent child makes new coverage elections during their employer's official open enrollment period (this does not include a new hire enrollment period)?	
Medical, Dental, or Vision **Note:** Interns and flexible employees are only eligible for medical coverage.	**You may enroll or add:** • Yourself if your same type of coverage is dropped during a spouse's employer's plan's official open enrollment period • Your spouse or eligible dependent children whose same type of coverage is dropped during your spouse's or dependent child's employer's plan's official open enrollment period • Your domestic partner or their eligible dependent children, to your existing coverage, if your domestic partner or domestic partner's child drops the same type of coverage during their employer's plan's official open enrollment period **You may drop:** • Yourself, your spouse, and any covered dependent children who become newly enrolled in the same type of coverage under your spouse's employer's plan as a result of their election during their employer's plan's official open enrollment period • Your covered dependent child who becomes newly enrolled in the same type of coverage under their employer's plan as a result of their election during the employer's plan's official open enrollment period • Your domestic partner or their eligible dependent children who become newly enrolled in the same type of coverage under your domestic partner's employer's plan as a result of their election during their employer's plan's official open enrollment period • Your domestic partner's child who becomes newly enrolled in the same type of coverage under their employer's plan as a result of their election during the employer's plan's official open enrollment period ***Reminder: If you elect to drop your coverage, coverage for any enrolled dependents, including your spouse or domestic partner, will also be dropped.*** **You may not** change benefit options with this event.
Full-Purpose Health Care FSA* and Limited Dental/ Vision FSA*	**You may not** make any changes to your FSA election.
Day Care FSA*	**Regular and fixed term employees may:** • Enroll or increase your FSA election if your spouse does not elect to make contributions to their employer's day care FSA (dependent care FSA) during your spouse's employer's plan's official open enrollment period • Enroll or increase your FSA election if your spouse's employer no longer offers a day care FSA or if contributions to your spouse's employer's day care FSA account are involuntarily decreased or stopped (at any time during the year) • Drop or decrease your FSA election if your spouse elects to make contributions to their employer's day care FSA during the employer's plan's official open enrollment period
Legal Services	**Regular and fixed term employees may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

* You may not make changes to your flexible spending account (FSA) elections as a result of new coverage elections by your domestic partner or their child.

Change in place of permanent residence	
What benefit election changes can you make when you, your spouse, or your dependent child has a permanent residential address change that affects eligibility for medical coverage at Wells Fargo?	
Medical **(Dental and Vision – no changes allowed with this event)**	**This applies to medical coverage only.** If you previously waived medical coverage and are eligible for a new medical benefit option as a result of a permanent residential address change, **you may** enroll in medical coverage for: • Yourself • Your spouse • Your eligible dependent children ***Reminder: If you want to enroll your spouse or eligible dependent children, you must also enroll.*** **You may drop** coverage for a spouse or dependent who has a permanent residential address change to an address outside the United States. If you previously waived or dropped medical coverage for your spouse or a dependent because they resided outside of the United States (U.S.), when they move back to the U.S., you may enroll that individual who moved back to the United States under your existing medical coverage. **You may change medical benefit options *only if*** your permanent residential address change results in a new benefit option or loss of your current benefit option. ***Reminder: If your change in permanent residential address results in loss of eligibility for your current medical plan option, you will have to change plans or drop coverage. If your change in permanent residence is outside the 50 states within the United States, you are no longer eligible to be enrolled in a medical benefit option and your medical coverage will automatically be dropped. See the "If you move" section starting on page 1-22 for more information.***
Full-Purpose Health Care FSA and Limited Dental/ Vision FSA	**You may not** make any changes to your FSA election.
Day Care FSA	Regular and fixed term employees, see the "Change in day care services or needs" section on page 1-38 of this Qualified Events table.
Legal Services	**Regular and fixed term employees may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

Change in day care services or needs	
What benefit election changes can you make when your day care services change or your day care needs change?	
Medical, Dental, or Vision	**You may not** make changes to your benefit elections.
Full-Purpose Health Care FSA and Limited Dental/ Vision FSA	**You may not** make changes to your FSA election.
Day Care FSA	**Regular and fixed term employees may:** • Enroll or increase your FSA election if you change day care providers or have a change in the services provided (such as hours, cost, location, or availability of service) by your current day care provider that increases your qualified day care expenses • Enroll if you start day care services (for example, as a result of returning to Wells Fargo in a regular or fixed term position after having been on a leave of absence) and will incur qualified day care expenses • Decrease your FSA election if you have a change in day care providers or a change in services provided (such as hours, cost, location, or availability of service) by your current day care provider that reduces your qualified day care expenses • Drop your FSA election if you no longer need day care services (for example, as a result of taking a leave of absence from Wells Fargo or your child is no longer eligible)
Legal Services	**You may not** make changes to your benefit election.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Generally, a change in day care needs does not impact these benefits. Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

Medicare, Medicaid, or CHIP entitlement	
1. What benefit election changes can you make when you, your spouse or domestic partner, or your dependent child becomes entitled to coverage (meaning the individual becomes enrolled in such coverage) under Medicare Part A or Part B, or Medicaid?	
Medical **(Dental and Vision – no changes allowed with this event)**	**This only applies to medical coverage.** **You may** drop medical coverage only for the individual who becomes entitled to coverage (meaning becomes enrolled) under Medicare Part A or Part B, or Medicaid. ***Reminder: If you elect to drop your coverage, coverage for any enrolled dependents, including your spouse or domestic partner, will also be dropped.*** **You may not** change benefit options with this event.
Full-Purpose Health Care FSA and Limited Dental/ Vision FSA	**You may** drop or decrease your FSA election if you, your spouse, or your eligible dependent children become entitled to coverage (meaning become enrolled) under Medicare Part A or Part B, or Medicaid. **You may** only drop or decrease your FSA election if your domestic partner (or their eligible dependent child) qualifies, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment for federal income tax purposes and becomes entitled to coverage (meaning becomes enrolled) under Medicare Part A or Part B, or Medicaid. **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA	**You may not** make any changes to your FSA election.
Legal Services	**You may not** make changes to your benefit election.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	A change in entitlement to Medicare or Medicaid does not impact these benefits. Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

2. What benefit election changes can you make when you, your spouse or domestic partner, or your dependent child becomes entitled to coverage (meaning the individual is enrolled in such coverage) under CHIP?	
Medical **(Dental and Vision – no changes allowed with this event)**	**This only applies to medical coverage.** **You may** drop medical coverage for the individual who becomes entitled to coverage (meaning becomes enrolled) under CHIP. ***Reminder: If you elect to drop your coverage, coverage for any enrolled dependents, including your spouse or domestic partner, will also be dropped.*** **You may not** change benefit options with this event.
Full-Purpose Health Care FSA and Limited Dental/ Vision FSA	**You may not** make changes to your FSA election.
Day Care FSA	**You may not** make changes to your FSA election.
Legal Services	**You may not** make changes to your benefit election.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Enrollment in CHIP does not impact these benefits. Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

New eligibility for Medicaid or CHIP subsidy	
What benefit election changes can you make when you, your spouse or domestic partner, or your dependent child becomes entitled to a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP)?	
Medical **(Dental and Vision – no changes allowed with this event)**	**This only applies to medical coverage and you may only add medical coverage for the individual who became entitled to a premium assistance subsidy under Medicaid or CHIP.** **You may add:** • Yourself • Your spouse or domestic partner • Your eligible dependent children ***Reminder: If you are not enrolled in medical coverage at Wells Fargo, you must enroll in order to enroll a spouse or domestic partner or eligible dependent child.*** **You may change medical benefit options** if you add your spouse or domestic partner or your eligible dependent child to your existing medical coverage.
Full-Purpose Health Care FSA and Limited Dental/ Vision FSA	**You may not** make changes to your FSA election.
Day Care FSA	**You may not** make changes to your FSA election.
Legal Services	**You may not** make changes to your benefit election.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Eligibility for a Medicaid or CHIP subsidy does not impact these benefits. Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

Medicare — loss of eligibility	
What benefit election changes can you make when you, your spouse or domestic partner, or your dependent child loses eligibility for Medicare Part A or Part B? (Does not apply to voluntarily dropping coverage, including not reapplying for coverage or loss of coverage for nonpayment of premiums.)	
Medical **(Dental and Vision – no changes allowed with this event)**	**This only applies to medical coverage and you may only add medical coverage for the individual who lost eligibility for Medicare Part A or Part B.** **You may enroll or add:** • Yourself • Your spouse or domestic partner • Your eligible dependent children **You may not** change benefit options with this event.
Full-Purpose Health Care FSA and Limited Dental/ Vision FSA	**Regular and fixed term employees may** enroll or increase your election if you, your spouse, or your eligible dependent children lose eligibility under Medicare. **Regular and fixed term employees may** only enroll or increase your FSA election if your domestic partner qualifies, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment for federal income tax purposes and loses eligibility under Medicare. **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA	**You may not** make any changes to your FSA election.
Legal Services	**You may not** make changes to your benefit election.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	A change in eligibility for Medicare does not impact these benefits. Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

Medicaid or CHIP — loss of eligibility	
What benefit election changes can you make when you, your spouse or domestic partner, or your dependent child is no longer entitled to coverage (meaning the individual was enrolled in such coverage and has lost eligibility for coverage) under Medicaid or CHIP? (Does not apply to voluntarily dropping coverage, including not reapplying for coverage, or loss of coverage for nonpayment of premiums.)	
Medical **(Dental and Vision – no changes allowed with this event)**	**This only applies to medical coverage and you may only add medical coverage for the individual who lost entitlement to coverage (meaning the individual was enrolled in such coverage and has lost eligibility for coverage) under Medicaid or CHIP.** **You may add:** • Yourself • Your spouse or domestic partner • Your eligible dependent children ***Reminder: If you want to enroll your spouse, domestic partner, or eligible dependent children in medical coverage, you must also enroll or be enrolled.*** **Regular and fixed term employees may change medical benefit options if** you add your spouse or domestic partner or your eligible dependent child to your existing medical coverage.
Full-Purpose Health Care FSA and Limited Dental/ Vision FSA	**Regular and fixed term employees may** enroll or increase your FSA election. **You may not:** • Enroll or increase your FSA election if you enroll your domestic partner or domestic partner's children, unless they qualify, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment for federal income tax purposes • Drop or decrease your FSA election • Change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa
Day Care FSA	**You may not** make changes to your FSA election.
Legal Services	**You may not** make changes to your benefit election.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Loss of coverage under Medicaid or CHIP does not impact these benefits. Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

Judgments, decrees, or orders that require an employee to provide coverage for a dependent child	
What benefit election changes can you make when a judgment, decree, or court order (such as a Qualified Medical Child Support Order or National Medical Support Order) ***requires*** *you, the employee, to provide coverage for a dependent child?*	
Medical,[1,2] Dental,[1,2] or Vision[1,2] **Note:** Interns and flexible employees are only eligible for medical coverage, but generally required premiums will likely exceed any applicable withholding threshold. In that case, the child will not be added to coverage.	**You may enroll:** • Your eligible dependent child who is the subject of a Qualified Medical Child Support Order or National Support Order • Your newly eligible dependent child when a recent judgment, decree, or order establishes that you, the employee, are the parent, legal guardian, or legal custodian • Your eligible dependent child when a judgment; decree; or court order resulting from a divorce, legal separation, annulment, legal custody arrangement, or newly identified paternity requires you, the employee, to provide coverage for your eligible dependent child ***Reminder: If you are not enrolled, you must enroll to comply with the order to add the eligible dependent child to coverage.*** **You may not enroll:** • Your spouse or domestic partner • Your other eligible dependent children **You will only be able to change** benefit options as stipulated within a qualified order.
Full-Purpose Health Care FSA[2] and Limited Dental/ Vision FSA[2]	**Regular and fixed term employees may** enroll or increase your FSA election. **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA	**You may not** make any changes to your FSA election.
Legal Services	**You may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

1. The child may only be enrolled in the specific coverage type required by the order (for example, if the order requires medical coverage, the child will be enrolled in medical coverage but not dental or vision coverage).

2. You may not make changes to your benefit elections if your spouse or domestic partner or dependent child is ordered to provide coverage for a dependent child.

Judgments, decrees, or orders that require another individual to provide coverage	
What benefit election changes can you make when a judgment; decree; or court order resulting from a divorce, legal separation, annulment, legal custody arrangement, or newly identified paternity requires that another individual provide coverage for your dependent child or a judgment, decree, or court order eliminates your legal custody of a dependent child?	
Medical,[1,2] Dental,[1,2] or Vision[1,2] **Note:** Interns and flexible employees are only eligible for medical coverage.	**You may** drop your covered dependent child who is the subject of a court order requiring another individual to provide the same type of coverage for that child, for whom legal custody is terminated, or for whom you have been determined not to be the biological parent. **You may not drop** coverage for: • Yourself • Your spouse or domestic partner • Your other eligible dependent children **You may not change** benefit options with this event.
Full-Purpose Health Care FSA[2] and Limited Dental/ Vision FSA[2]	**You may** drop or decrease your FSA election. **You may** only drop or decrease your FSA election if your domestic partner's child has been dropped from coverage and qualifies, for purposes of Wells Fargo-sponsored coverage, for before-tax treatment for federal income tax purposes. **You may not** change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.
Day Care FSA	**You may not** make any changes to your FSA election.
Legal Services	**You may** enroll, increase, decrease, or drop coverage.
Life Insurance, AD&D, Optional Critical Illness Insurance, Optional Accident Insurance, and Disability Plans	Regular and fixed term employees, refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

1. The child may only be dropped from the specific coverage type that another individual is required to provide under the order (for example, if the order requires another person to provide medical coverage for the child, the child can be dropped from your medical coverage at Wells Fargo but cannot be dropped from dental or vision coverage).
2. You may not make changes to your benefit elections if your spouse or domestic partner or dependent child is ordered to provide coverage for a dependent child.

Dropping ineligible dependents

Dropping ineligible dependents during the plan year

If, at any time after you enroll, your covered dependent no longer meets the eligibility requirements (for example, divorce of a spouse, legal separation, or any other event that results in a loss of eligibility), you must drop coverage online in Workday, under Change Benefits, within 60 days of the date your dependent no longer meets the dependent eligibility. If you are unable to drop coverage in Workday or do not have access to Workday, you must call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days of the date your dependent no longer meets the dependent eligibility requirements to drop their coverage. For more information about dependent eligibility, see the "Eligible dependents" section starting on page 1-6.

Dependents who lose group health plan coverage because they become ineligible may be eligible for COBRA. For more information, see "Appendix E: Continuing Coverage Under COBRA." If you wait longer than 60 days after the date your dependent no longer meets the dependent eligibility requirements to drop their coverage, the dependent may lose all COBRA continuation rights. In addition, you may be required to repay the plan for any claims paid by the plan that were incurred after the coverage termination date.

Effective date

Except in cases of misrepresentation or fraud, termination of coverage due to a dependent's loss of eligibility is effective at the end of the month following the date of the event causing loss of eligibility or the end of the month following the date you drop their coverage, whichever is later. The actual change in coverage and corresponding cost for coverage becomes effective the first of the following month. However, termination of the dependent's coverage due to death is effective on the date of death. For potential consequences related to misrepresentation or fraud, or having an ineligible dependent enrolled in the plans, see the "Consequences of fraudulent enrollment" section on page 1-9.

Dropping dependents during Annual Benefits Enrollment

During Annual Benefits Enrollment, you may drop any covered dependent not covered by a QMSCO order from your coverage.

If you drop your spouse or domestic partner from benefits during Annual Benefits Enrollment, and the drop is in anticipation of a legal separation, divorce, or termination of partnership, the spouse or domestic partner may be eligible for COBRA continuation of coverage if the legal separation, divorce, or termination of partnership occurs within one year after the Annual Benefits Enrollment period in which they were dropped from coverage. In that case, to request COBRA coverage for the ex-spouse or former domestic partner, you must call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) within 60 days of the legal separation, divorce, or termination of partnership to request COBRA coverage. For more information on COBRA, refer to "Appendix E: Continuing Coverage Under COBRA." All other dependents who are voluntarily dropped from benefits during Annual Benefits Enrollment are not eligible for COBRA continuation coverage.

If you have dropped a spouse, domestic partner, or other covered dependent during Annual Benefits Enrollment, you may not add them back to your coverage during the year unless you experience a corresponding Qualified Event or special enrollment event (see the "Changing coverage" section starting on page 1-20).

Effective date

Changes made during Annual Benefits Enrollment and the corresponding cost for coverage go into effect on January 1 of the following plan year.

Dropping a dependent who becomes a Wells Fargo employee or a covered dependent of another Wells Fargo employee

In the event that one of your covered dependents becomes a Wells Fargo employee and elects coverage as an employee, they are no longer an eligible dependent under the benefit plan options and must be dropped from your coverage. You must drop coverage online in Workday. If you are unable to make the election change in Workday, you must call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to remove this dependent from coverage. **Note:** This requirement does not apply to coverage under the Life Insurance Plan and AD&D Plan.

In the event that one of your covered dependents becomes a covered dependent under another Wells Fargo employee, they are no longer eligible to be covered under your benefit plan options and must be dropped from your coverage. You must call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to drop this dependent from coverage.

Effective date

The dependent's coverage will end as of the date their own employee coverage begins with Wells Fargo or the date their coverage is effective under the other Wells Fargo-sponsored benefit option if you call Employee Care prior to your dependent's coverage becoming effective. If you call Employee Care after your dependent's coverage effective date, the coverage will drop the last day of the month in which you call Employee Care. The applicable change in premium or contribution will take effect on the next available pay period following the date you call Employee Care.

Dropping a dependent who becomes enrolled in the Wells Fargo & Company Retiree Plan

In the event that your spouse or domestic partner becomes a Wells Fargo retiree and elects coverage in the Wells Fargo Retiree Plan ("Retiree Plan"), they are no longer an eligible dependent under the Wells Fargo & Company Health Plan ("Health Plan") and must be dropped from your employee medical, dental, and vision coverage. In the event that your dependent child becomes a covered dependent under the Retiree Plan, they are no longer an eligible dependent under the Health Plan and must be dropped from your employee medical, dental, and vision coverage. You must drop coverage online in Workday. If you are unable to make the election change in Workday, you must call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to remove the ineligible dependent from coverage.

Effective date

The dependent's Health Plan coverage will end as of the date their coverage begins under the Retiree Plan. If you call Employee Care after your dependent's Retiree Plan coverage effective date, the dependent coverage under the Health Plan will drop the last day of the month in which you call Employee Care. The applicable change in premium or contribution under the Health Plan will take effect on the next available pay period following the date you call Employee Care.

Dropping your coverage

You may drop your medical, dental, vision, legal services, life insurance, accidental death and dismemberment, optional critical illness insurance, or optional accident insurance coverage during the Annual Benefits Enrollment period. See the "Annual Benefits Enrollment" section starting on page 1-21 for more information.

You may not drop your medical, dental, vision, and legal services coverage or your participation in a flexible spending account during the plan year unless you have a Qualified Event and your election to drop your coverage is consistent with the Qualified Event. If you don't have a Qualified Event during the plan year, you must wait until the next Annual Benefits Enrollment period to drop coverage. See the "Annual Benefits Enrollment" section starting on page 1-21 and the "Qualified Events" section starting on page 1-24 for more information.

When you are required to drop coverage for a dependent who is no longer eligible, you cannot drop medical, dental, or vision coverage for yourself or any other covered dependents.

You may drop your optional LTD, accidental death and dismemberment, life insurance, optional critical illness insurance, or optional accident insurance coverage at any time by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

Effective date

Outside of Annual Benefits Enrollment, your permitted drop of coverage and discontinuation of applicable contributions or premiums for coverage are effective the first of the month following the date of the event or the date you make the change, whichever is later.

Coverage when you are not working

Coverage while on a leave of absence

Refer to "Appendix D: Leaves of Absence and Your Benefits" in this *Benefits Book*.

Coverage if your employment terminates

Generally, coverage ends at the end of the month in which employment terminates.

You may be able to continue your medical, dental, and vision coverage, and Full-Purpose Health Care Flexible Spending Account or Limited Dental/Vision Flexible Spending Account participation, under COBRA by making after-tax contributions. See "Appendix E: Continuing Coverage Under COBRA" for more information on continuing coverage under COBRA.

You may be able to convert or port your life insurance coverage, your accidental death and dismemberment coverage, and your legal services coverage and make premium payments directly to the applicable insurance company. Refer to the applicable chapters in this *Benefits Book* for more information.

Refer to the individual chapters in this *Benefits Book* for applicable claims filing processes and deadlines for any remaining claims.

Coverage for terminated employees who are receiving Wells Fargo severance pay

Terminated employees who are receiving severance pay under the Wells Fargo & Company Severance Plan are eligible to continue participating in the following Wells Fargo-sponsored voluntary benefit options as long as you continue to pay the required applicable contribution or premium which will be automatically deducted from your severance pay:

- Medical[1, 2]
- Dental
- Vision
- Full-Purpose Health Care FSA[2]
- Limited Dental/Vision FSA[2]
- Life Insurance (Basic Term Life,[3] Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverages)
- Accidental Death and Dismemberment
- Legal Services
- Optional Accident Insurance
- Critical Illness Insurance (Basic[3] and Optional)

Benefits will continue through the end of the month in which your final severance benefit under the Wells Fargo & Company Severance Plan is paid subject to "When coverage ends" as described in this chapter or any other applicable chapter in this *Benefits Book*. All other plan provisions apply.

1. If you are enrolled in a high-deductible health plan and make contributions to your HSA through pretax payroll contribution, your deduction will continue unless you make an election change by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.
2. If your severance pay continues from one year into the next, you will be required to make a new election for HSA or FSA contributions you want to be deducted in the new year.
3. Basic Term Life and Basic Critical Illness Insurance coverage continue at no cost to you.

Coverage if you retire

The following general information related to coverage if you retire is for informational purposes only and is not part of any plan or Summary Plan Description described in this *Benefits Book*. You may be eligible to enroll in retiree medical and dental coverage under the Wells Fargo & Company Retiree Plan when you retire, subject to the eligibility criteria under the Wells Fargo Retiree Plan. Refer to the *Retiree Benefits Book* on the HR Services & Support site for more information about your benefit options at retirement.

Refer to the individual chapters in this *Benefits Book* for applicable claims filing processes and deadlines for any remaining claims.

Coverage if you die

Coverage for the deceased ends on the date of death. Generally, when you die, coverage for your covered dependents ends at the end of the month in which you died. However, your covered dependents may be eligible to continue their group health coverage for a limited period of time under COBRA (see "Appendix E: Continuing Coverage Under COBRA" for more information).

Refer to the individual chapters in this *Benefits Book* for applicable claims filing processes and deadlines for any remaining claims.

When coverage ends

Employees

Employee coverage under the medical, dental, and vision benefit options ends on the last day of the month in which one of the following events occurs (or was processed, if later):

- Your last day of employment or the last day of your severance eligibility period under the Wells Fargo & Company Severance Plan, whichever is later
- You no longer meet the eligibility requirements
- You voluntarily make a permitted election change to drop coverage (**Exception:** If you make an election to drop coverage during Annual Benefits Enrollment, that coverage ends December 31 of the year in which the Annual Benefits Enrollment election was made)
- You die

Coverage under the plans will also end if you stop paying the required premiums or contributions or if the applicable plan or plan option is discontinued or terminated regardless of any of the events noted above.[2]

Coverage for your covered dependents ends when they no longer meet the eligibility requirements. Coverage for all of your covered dependents also ends when your coverage ends.

1. If you are rehired by Wells Fargo as a regular or fixed term employee with a first day of reemployment during your severance eligibility period, any benefits that are in effect on the day before your rehire date will continue as a rehired employee.
2. For information on Wells Fargo's ability to amend, modify, or terminate the plans, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

If you elected coverage under the Wells Fargo & Company International Plan, your medical coverage under the International Plan ends on the last day of the month in which your international assignment ends.

To determine when coverage ends under the Health Care Flexible Spending Account (Full-Purpose FSA or Limited Dental/Vision FSA), the Day Care Flexible Spending Account, the Life Insurance Plan, the Business Travel Accident Plan, the Accidental Death and Dismemberment Plan, the Short-Term Disability Plan, the Short-Term Disability Top-Up Plan, the Long-Term Disability Plan, the Legal Services Plan, the Critical Illness Insurance Plan, or the Optional Accidental Insurance Plan, refer to the applicable chapter in this *Benefits Book*.

If your coverage is COBRA continuation coverage, also refer to "Appendix E: Continuing Coverage Under COBRA" for additional information about when COBRA continuation coverage ends.

Dependents

Coverage for dependents ends when your coverage ends. Dependent coverage also ends on the last day of the month in which you make the change for any of the following events:

- For a spouse, when there is a legal separation or the marriage is dissolved.
- For a domestic partner, when the domestic partnership terminates.
- For any dependent, when they no longer meet dependent eligibility requirements.
- For a spouse, domestic partner, or dependent child, when you voluntarily make a permitted election to drop coverage of that individual with an applicable Qualified Event. (**Exception:** If you make an election to drop coverage for a dependent during Annual Benefits Enrollment, that coverage ends December 31 of the year in which the Annual Benefits Enrollment election was made.)
- Your dependent dies. (Coverage ends on the date of death.)

Refer to "Appendix E: Continuing Coverage Under COBRA" to determine when COBRA continuation coverage ends.

Except in cases of misrepresentation or fraud, termination of coverage due to a dependent's loss of eligibility is effective at the end of the month following the date of the event causing loss of eligibility or at the end of the month following the date that you make the change, whichever is later. In cases of misrepresentation or fraud, an ineligible dependent's coverage will end at the end of the month in which eligibility is lost, in accordance with notice provided by the plan administrator. For potential consequences related to misrepresentation or fraud, see the "Consequences of fraudulent enrollment" section on page 1-9.

Summary Plan Descriptions for each benefit plan

Benefit plan name	Benefit option	SPD components
Wells Fargo & Company Health Plan	Copay Plan with HRA (including Copay Plan with HRA Out of Area coverage) (self-insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 2: Medical Plans" • "Appendix A: Claims and Appeals" • "Appendix B: Important Notifications and Disclosures" • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Plan	Higher Use Plan with HSA (including Higher Use Plan with HSA Out of Area coverage) (self-insured) The health savings account you set up separately is not a Wells Fargo-sponsored plan. For more information on the health savings account, refer to "Appendix C: Health Savings Accounts."	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 2: Medical Plans" • "Appendix A: Claims and Appeals" • "Appendix B: Important Notifications and Disclosures" • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Plan	Lower Use Plan with HSA (including Lower Use Plan with HSA Out of Area coverage) (self-insured) The health savings account you set up separately is not a Wells Fargo-sponsored plan. For more information on the health savings account, refer to "Appendix C: Health Savings Accounts."	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 2: Medical Plans" • "Appendix A: Claims and Appeals" • "Appendix B: Important Notifications and Disclosures" • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Plan	Narrow Network Plan with HSA	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 2: Medical Plans" • "Appendix A: Claims and Appeals" • "Appendix B: Important Notifications and Disclosures" • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Plan	Narrow Network Copay Plan	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 2: Medical Plans" • "Appendix A: Claims and Appeals" • "Appendix B: Important Notifications and Disclosures" • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Plan	HMO — Kaiser[1] Available in certain locations (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 2: Medical Plans" – Only "The Basics" section (excluding the "Self-insured medical plan options" subsection) and the "Health and wellness activities" section applies • "Appendix B: Important Notifications and Disclosures" • Kaiser Evidence of Coverage (provided by Kaiser; visit https://my.kp.org/wf or kp.org/eoc) • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"

1. If the information provided by an insurer or HMO conflicts with the information listed in the applicable chapters or appendixes in this *Benefits Book*, the information in this book supersedes and is controlling.

Benefit plan name	Benefit option	SPD components
Wells Fargo & Company Health Plan	High-Deductible Health Plan (HDHP) — Kaiser[1] Available in certain locations (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 2: Medical Plans" – Only "The Basics" section (excluding the "Self-insured medical plan options" subsection) and the "Health and wellness activities" section applies • "Appendix B: Important Notifications and Disclosures" • Kaiser Evidence of Coverage (provided by Kaiser; visit https://my.kp.org/wf or kp.org/eoc) • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Plan	POS Kaiser Added Choice — Hawaii[1] Available in Hawaii only (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 2: Medical Plans" – Only "The Basics" section (excluding the "Self-insured medical plan options" subsection) and the "Health and wellness activities" section applies • "Appendix B: Important Notifications and Disclosures" • Kaiser Evidence of Coverage (provided by Kaiser; visit https://my.kp.org/wf or kp.org/eoc) • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Plan	Delta Dental (dental plan) • Standard (self-insured) • Enhanced (self-insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 3: Dental Plan" • "Appendix A: Claims and Appeals" • "Appendix B: Important Notifications and Disclosures"[2] • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Plan	Vision Service Plan (vision plan) (self-insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 4: Vision Plan" • "Appendix A: Claims and Appeals" • "Appendix B: Important Notifications and Disclosures"[2] • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company International Plan	UnitedHealthcare Global — Expatriate Insurance[1] (for expatriates only) (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Appendix B: Important Notifications and Disclosures" • Certificate of Coverage • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Care Flexible Spending Account Plan	• Full-Purpose Health Care Flexible Spending Account • Limited Dental/Vision Flexible Spending Account	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 5: Health Care Flexible Spending Account Plan (Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)" • "Appendix A: Claims and Appeals" • "Appendix B: Important Notifications and Disclosures"[2] • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"

1. If the information provided by an insurer or HMO conflicts with the information listed in the applicable chapters or appendixes in this *Benefits Book*, the information in this book supersedes and is controlling.

2. Only the "Your rights under ERISA," "Plan information," "Participating employers," and "Future of the plans" sections apply.

Benefit plan name	Benefit option	SPD components
Wells Fargo & Company Day Care Flexible Spending Account Plan	Day Care Flexible Spending Account	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 6: Day Care Flexible Spending Account" • "Appendix B: Important Notifications and Disclosures" – Only the "Plan information," "Participating employers," and "Future of the plans" sections apply • "Appendix D: Leaves of Absence and Your Benefits"
Wells Fargo & Company Life Insurance Plan	• Basic Term Life coverage (insured) • Optional Term Life coverage (insured) • Spouse/Partner Optional Term Life coverage (insured) • Dependent Term Life coverage (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 7: Life Insurance Plan" • "Appendix B: Important Notifications and Disclosures"[1, 2] • "Appendix D: Leaves of Absence and Your Benefits"
Wells Fargo & Company Business Travel Accident Plan	Business Travel Accident (BTA) Plan (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 8: Business Travel Accident Plan" • "Appendix B: Important Notifications and Disclosures"[1, 2]
Wells Fargo & Company Accidental Death and Dismemberment Plan	Accidental Death and Dismemberment (AD&D) Plan (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 9: Accidental Death and Dismemberment Plan" • "Appendix B: Important Notifications and Disclosures"[1, 2] • "Appendix D: Leaves of Absence and Your Benefits"
Wells Fargo & Company Short-Term Disability Plan	Short-Term Disability (STD) Plan (self-insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 10: Short-Term Disability Plan" • "Appendix B: Important Notifications and Disclosures"[2] • "Appendix D: Leaves of Absence and Your Benefits"
Wells Fargo & Company Short -Term Disability Top-Up Plan	Short-Term Disability Top-Up Plan	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 11: Short-Term Disability Top-Up Plan" • "Appendix B: Important Notifications and Disclosures"[2] • "Appendix D: Leaves of Absence and Your Benefits"
Wells Fargo & Company Long-Term Disability Plan	Long-Term Disability (LTD) Plan (insured) • Basic long-term disability coverage • Optional long-term disability coverage	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 12: Long-Term Disability Plan" • "Appendix B: Important Notifications and Disclosures"[1, 2] • "Appendix D: Leaves of Absence and Your Benefits"

1. If the information provided by an insurer or HMO conflicts with the information listed in the applicable chapters or appendixes in this *Benefits Book*, the information in this book supersedes and is controlling.

2. Only the "Your rights under ERISA," "Plan information," "Participating employers," and "Future of the plans" sections apply.

Benefit plan name	Benefit option	SPD components
Wells Fargo & Company Critical Illness Insurance Plan	• Basic Critical Illness Insurance coverage (insured) • Optional Critical Illness Insurance coverage (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 14: Critical Illness Insurance Plan" • Certificate of Coverage • "Appendix B: Important Notifications and Disclosures"[1,2] • "Appendix D: Leaves of Absence and Your Benefits"
Wells Fargo & Company Optional Accident Insurance Plan	Optional Accident Insurance Plan (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 15: Optional Accident Insurance Plan" • Certificate of Coverage • "Appendix B: Important Notifications and Disclosures"[1,2] • "Appendix D: Leaves of Absence and Your Benefits"
Wells Fargo & Company Legal Services Plan	Legal Services Plan (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 15: Optional Accident Insurance Plan" • "Appendix B: Important Notifications and Disclosures" [1,2] • "Appendix D: Leaves of Absence and Your Benefits"

1. If the information provided by an insurer or HMO conflicts with the information listed in the applicable chapters or appendixes in this *Benefits Book*, the information in this book supersedes and is controlling.

2. Only the "Your rights under ERISA," "Plan information," "Participating employers," and "Future of the plans" sections apply.

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Chapter 2: Medical Plans

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Information about the medical plans administered by Anthem BCBS	1-866-418-7749 anthem.com Mobile app*: Engage Wellbeing (Anthem Healthcare)
Information about the medical plans administered by Aetna	1-877-320-4577 aetna.com Mobile app*: Aetna Health (Aetna Inc)
Information about prescription drug coverage administered by Express Scripts	1-855-388-0352 www.express-scripts.com Pre-enrollment site: www.express-scripts.com/wf Mobile app*: Express Scripts (Express Scripts Holding Company)
Information about the medical plans administered by Kaiser Permanente	Kaiser California (Northern and Southern) 1-800-464-4000 https://my.kp.org/wf Kaiser Colorado 1-800-632-9700 https://my.kp.org/wf Kaiser Georgia 1-888-865-5813 https://my.kp.org/wf Kaiser Hawaii 1-800-966-5955 https://my.kp.org/wf Kaiser Mid-Atlantic 301-468-6000 – D.C. area 1-800-777-7902 – Outside of D.C. area https://my.kp.org/wf Kaiser Northwest (Oregon and SW Washington) 1-800-813-2000 503-813-2000 – Portland https://my.kp.org/wf Kaiser Washington 1-800-813-2000 – Vancouver/Longview area only 1-888-901-4636 – All other areas https://my.kp.org/wf Mobile app:* Kaiser Permanente (Kaiser Permanente)
Information about earning health and wellness dollars as well as wellness-related activities	Rally Support 1-877-543-4294 wellness.myoptumhealth.com
Information about premiums	HR Services & Support site
Information about enrollment	HR Services & Support Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.

*This app should be used on personal devices only and should not be used on Wells Fargo-owned devices.

Medical plans by location

Medical Plan	Medical Claims Administrator	State
Copay Plan with HRA* **Higher Use Plan with HSA*** **Lower Use Plan with HSA*** **Flex HDHP*** * Including Out of Area, where applicable	UnitedHealthcare	Arkansas, Colorado, District of Columbia, Florida, Iowa, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, Tennessee, Utah, Wisconsin
	Anthem Blue Cross Blue Shield	Alabama, Alaska, Connecticut, Delaware, Idaho, Illinois, Indiana, Kentucky, Massachusetts, Michigan, Montana, Nevada, New Hampshire, North Carolina, North Dakota, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Virginia, West Virginia
	Aetna	Arizona, California – Northern, California – Southern, Georgia, Kansas, Maine, New Jersey, New York, Ohio, Oklahoma, Oregon, Washington, Wyoming
Narrow Network Copay Plan **Narrow Network Plan with HSA**	Aetna	Arizona (Phoenix area only), Iowa (Des Moines and certain other Iowa locations), Texas (Dallas, Fort Worth, Houston, and San Antonio areas only)
	Anthem Blue Cross Blue Shield	Missouri (St Louis Metro Area), North Carolina (Charlotte, Concord-Gastonia Metro Area)
	UnitedHealthcare	Illinois (Chicago area only), Minnesota (Minneapolis Metro area only)
Express Scripts is the prescription drug administrator for all of the plans listed above		
HMO — Kaiser	Kaiser Permanente	Available in certain locations within the following states: California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington, and the District of Columbia (Washington, D.C.). To find out if Kaiser is available in your location, view your plan options from the Your Benefits Tool or by using the ALEX benefits counselor.
High-Deductible Health Plan (HDHP) — Kaiser	Kaiser Permanente	Available in certain locations within the following states: California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington, and the District of Columbia (Washington, D.C.). To find out if Kaiser is available in your location, view your plan options from the Your Benefits Tool or by using the ALEX benefits counselor.
POS Kaiser Added Choice — Hawaii	Kaiser Permanente	Hawaii

Note:

- Eligibility for the Narrow Network and Kaiser medical plans is limited to regular and fixed term employees whose permanent residential address is within the applicable service area
- If your permanent home address on record is outside the 50 states within the United States, you are not eligible to be enrolled in a medical benefit option under the Health Plan. However, if you change your home address to an address outside the 50 states within the United States and you are on International Assignment, you may be eligible for medical coverage under the Wells Fargo & Company International Plan (see the "Additional requirements for the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance" section in "Chapter 1: Eligibility, Enrollment, and More").

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix A: Claims and Appeals," "Appendix B: Important Notifications and Disclosures," "Appendix D: Leaves of Absence and Your Benefits," and "Appendix E: Continuing Coverage Under COBRA" — constitutes the Summary Plan Description (SPD) for your medical plan. The medical plan option in which you enroll is considered your "medical plan."

The basics

General information

Wells Fargo sponsors various medical plan options as part of the Wells Fargo & Company Health Plan ("Health Plan"). Refer to the "Medical plans by location" starting on page 2-5 to determine the medical plan options available to you.

The Health Plan is a group health plan and is classified as a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

You must be enrolled in a medical plan on the date of service to receive applicable benefits under that medical plan (see the "Insured medical plan options" on page 2-8 and the "Self-insured medical plan options" on page 2-8 for more information).

When you enroll in one of the medical plan options, you agree to give your health care providers permission to provide the applicable claims administrator access to required information about the care provided to you. The claims administrator may require this information to process claims and conduct utilization review, for quality improvement activities and for other health plan activities including, but not limited to, sharing information with other medical claims administrators, pharmacy claims administrators, and the wellness administrator, as permitted by law.

The claims administrator may release your personal health information, if you authorize it to do so or if state or federal law permits or allows release without your authorization. If a provider requires a special authorization for release of records, you agree to provide the authorization. Your failure to provide authorization or requested information may result in denial of your claim.

As always, it is between you and your provider to determine the services and supplies you will receive. The provisions governing your medical plan control what, if any, benefits are available for the services you receive. The fact that a physician has performed or prescribed a procedure or treatment, or the fact that it may be the only treatment for a condition, sickness, or illness does not mean that it is a covered health service. Under each of the medical plans, the definition of a covered health service relates only to what is covered by the medical plan and may differ from what your physician believes should be a covered health service.

Who's eligible

- Regular and fixed term employees are eligible to enroll in any of the medical plan choices available in their geographic area, except the Flex HDHP.
- Interns and flexible employees in all states but Hawaii are only eligible to enroll in the Flex HDHP. Interns and flexible employees in Hawaii are only eligible to enroll in Kaiser POS Added Choice Hawaii.

If you are enrolled as an eligible employee, you may also cover your eligible dependents including your spouse or domestic partner. However, you may not be covered under the medical plan as both an employee and a spouse or domestic partner of another employee, or as an employee and a dependent child of another employee at the same time. Also, a dependent can only be covered under one employee. Detailed eligibility requirements are described in the "Who's eligible to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

How to enroll and when coverage begins

Refer to the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment. After you have enrolled, coverage will begin as described in the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More."

Changing or canceling coverage

You may make changes to your enrollment election during the Annual Benefits Enrollment period or if you experience certain Qualified Events or a special enrollment right during the year. For more information on making enrollment election changes, refer to the "Changing coverage" section in "Chapter 1: Eligibility, Enrollment, and More."

When coverage ends

Medical coverage for you or any enrolled dependents ends as described in the "When coverage ends" section in "Chapter 1: Eligibility, Enrollment, and More."

Cost

You must make contributions to pay for the cost of medical coverage for yourself and any covered dependents. If you enroll in a medical plan under the Wells Fargo & Company Health Plan, your cost for medical coverage will be determined by the plan you elect and your level of coverage under that medical plan. If you are a regular or fixed term employee, your cost is also determined in part by your medical premium compensation category as described below.

For information on paying for coverage, refer to the "Cost and funding" section in "Chapter 1: Eligibility, Enrollment, and More."

Coverage:

- You only
- You + spouse*
- You + children
- You + spouse* + children

* The term "spouse" includes your domestic partner

Medical premium compensation category:

- Eligible compensation of less than $45,000
- Eligible compensation of $45,000 to $100,000
- Eligible compensation of more than $100,000

The Plan Administrator of the Wells Fargo & Company Health Plan, or its designee, has the ability to determine eligible compensation categories. Wells Fargo has the right to make changes to your eligible compensation category as necessary.

Your medical premium compensation category is determined by your eligible compensation. The eligible compensation amount is maintained by Human Resources (HR) and this determination shall be conclusive. As a general rule, this amount is outlined by pay category as described below. The corresponding job class assignment for each pay category is also listed below. Job class codes are assigned by Wells Fargo Rewards and Performance Management.

Find your medical eligible compensation on Workday by navigating to View profile, then Actions, then Benefits, and then View Benefits Annual Rate.

- **For Annual Benefits Enrollment elections**

  Your eligible compensation for your medical premium compensation category is determined for the next plan year at Annual Benefits Enrollment based on salary and payroll information on October 1 of the current plan year.[1]

  – *Pay category — salaried employees, job class 2*

    Eligible compensation is based on your annual base salary[2] as of October 1 plus any eligible incentive compensation[3] paid to you by Wells Fargo in the 12 months prior to October 1, and remains the same throughout the year.[1]

  – *Pay category — hourly employees, job class 2*

    Eligible compensation is based on your annual base salary[2] (your standard hours[4] multiplied by your hourly wage by 52 weeks) as of October 1 plus any eligible incentive compensation[3] paid to you by Wells Fargo in the 12 months prior to October 1, and remains the same throughout the year.[1]

  – *Pay category — Variable Incentive Compensation (VIC), job class 5, and Mortgage Consultant Participant, job class 1*

    Your medical eligible compensation is determined by annualizing your earnings based on any eligible incentive compensation[3] paid to you by Wells Fargo in the prior 12 months, and remains the same throughout the year.[1]

- **For employees on an approved leave of absence**

  Eligible compensation for your medical premiums is determined for the next plan year at Annual Benefits Enrollment by your pay category, as defined in the previous "For Annual Benefits Enrollment elections" section.

- **For newly hired benefits-eligible employees (including employees who become newly eligible and rehired retirees and employees)**

  Your eligible compensation for your medical premium compensation category is based on salary and payroll information as of your date of hire (or rehire) or the date you become newly eligible, as applicable, and remains in effect for the remainder of the current plan year as long as you continue to be eligible for benefits.[1]

  – *Pay category — salaried employees, job class 2*

    Eligible compensation is determined based on your annual base salary[2] as of your hire (or rehire) date or date you become newly eligible, as applicable. In addition, if any eligible incentive compensation[3] was paid to you by Wells Fargo in the prior 12 months, that may also be included.

  – *Pay category — hourly employees, job class 2*

    Eligible compensation is determined based on your annual base salary[2] (your standard hours[4] multiplied by your hourly wage multiplied by 52 weeks) as of your hire (or rehire) date or date you become newly eligible, as applicable. In addition, if any eligible incentive compensation[3] was paid to you by Wells Fargo in the prior 12 months, that may also be included.

  – *Pay category — Variable Incentive Compensation (VIC), job class 5, and Mortgage Consultant Participant, job class 1*

    Eligible compensation is determined by annualizing your earnings as of your hire (or rehire) date or date you become newly eligible, as applicable, based on eligible incentive compensation[3] paid to you by Wells Fargo in the prior 12 months.

1. Wells Fargo has the right to make changes to your eligible compensation category as necessary.
2. Annual base salary is your monthly or hourly rate of pay indicated on Workday with monthly and hourly pay annualized for the purpose of determining your compensation for medical premiums.
3. Eligible incentive compensation includes commissions, bonuses, and other earnings indicated on Workday as eligible incentive compensation.
4. Your standard hours are the hours that you're expected to work each week, as maintained on Workday and by your manager in the Staff Management online tool, and are not the same as scheduled hours. Overtime pay and shift differential are excluded.

Insured medical plan options

Noted below are the fully insured medical plans under the Wells Fargo & Company Health Plan:

- For regular and fixed term employees:
  - HDHP — Kaiser*
  - HMO — Kaiser
- For regular, fixed term, intern, and flexible employees who live in Hawaii:
  - Kaiser POS Added Choice — Hawaii medical

* The health savings account that you open in conjunction with your enrollment in the HDHP — Kaiser medical plans is not part of the Health Plan or any other ERISA-covered benefit plan sponsored by Wells Fargo. See "Appendix C: Health Savings Accounts" for more information about the health savings account.

Mid-year enrollment in a Kaiser medical plan option: If you enroll in the one of the Kaiser medical plan options under the Wells Fargo & Company Health Plan mid-year as the result of changing from another medical plan option under the Wells Fargo & Company Health Plan (without a gap in coverage), you will need to take action to transfer amounts applied to your deductible or out-of-pocket maximum for the current plan year under the previous medical plan option to the applicable Kaiser medical plan option. If you change medical benefit options mid-year from either the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, Narrow Network Copay Plan, or Flex HDHP and enroll in one of the Wells Fargo sponsored Kaiser medical plan options, you must provide a copy of your (and if applicable, your dependent's) most recent current year's explanation of benefits (EOB) statement to Kaiser in order for the current year's annual deductible and out-of-pocket maximum accumulations to transfer to your Kaiser medical plan option.

Insurer and Claims administrator

Kaiser Permanente or its applicable regional Kaiser subsidiary is the insurer and named claims and appeals fiduciary for the respective Kaiser medical plan options, including corresponding prescription drug coverage. Kaiser has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the applicable medical plan option in which you are enrolled and to interpret the terms of that plan option with regard to available benefits.

Plan documentation

The following documents apply to the Kaiser insured options:

- The Kaiser evidence of coverage provides the descriptions of plan benefits and the process for receiving benefits from Kaiser for these insured medical plan options. Separate documentation is provided directly from or made available to you by Kaiser if you enroll in the applicable plan (visit https://my.kp.org/wf or kp.org/eoc).
- Information noted in the following sections of this chapter:
  - The "Basics" section on page 2-146, excluding the "Self-insured medical plan options" subsection
  - The "Health and wellness activities" section starting on page 2-37, unless otherwise noted

  Note: Any additional information in this chapter describing the benefits and processes related to the self-insured medical plan options listed below does not apply to these Kaiser medical plan options.
- Information (including references to applicable appendices) specified as applying to Kaiser insured medical plan options in "Chapter 1: Eligibility, Enrollment, and More."

Self-insured medical plan options

Noted below are the self-insured medical plans under the Wells Fargo & Company Health Plan:

- For regular and fixed term employees:
  - Copay Plan with Health Reimbursement Account (HRA)*
  - Higher Use Plan with Health Savings Account (HSA)*
  - Lower Use Plan with Health Savings Account (HSA)*
  - Narrow Network Plan with Health Savings Account (HSA)
  - Narrow Network Copay Plan
- For interns and flexible employees:
  - Flexible High Deductible Health Plan (Flex HDHP)*

* Including Out of Area coverage. Unless otherwise indicated, references in this chapter to the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, and Flex HDHP apply to the applicable Out of Area coverage.

Note: The health savings account that you open in conjunction with your enrollment in the Higher Use Plan with HSA, Lower Use Plan with HSA, or the Narrow Network Plan with HSA is not part of the Health Plan or any other ERISA-covered benefit plan sponsored by Wells Fargo. See "Appendix C: Health Savings Accounts" for more information about the health savings account.

Mid-year enrollment in a self-insured medical plan option:

If you make a midyear enrollment election or a make a midyear change to your medical election, refer to the following sections for more information on how your election will impact your medical coverage:

- "How the Copay Plan with HRA works" section starting on page 2-13
- "How the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, and Flex HDHP work" section starting on page 2-23
- "How the Narrow Network Copay Plan works" section starting on page 2-32
- "Health and wellness activities" section starting on page 2-37

Claims administrator

The Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, the Narrow Network Copay Plan, and Flex HDHP options are self-insured. However, third-party administrators, known as claims administrators, provide claims administrative services. The state in which you reside determines which claims administrator provides these services for your medical claims. Refer to the "Medical plans by location" starting on page 2-5.

For prescription drug coverage, Express Scripts is the claims administrator for each of these medical plans.

The applicable claims administrator is the named claims and appeals fiduciary for the respective medical plan and prescription drug coverage; each has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the medical plan in which you are enrolled and to interpret the terms of the plan.

Plan documentation

The following applies to the self-insured medical plan options:

- Information noted in the following sections of this chapter:
  - The "Basics" see page 2-146, excluding the "Insured medical plan options" subsection
  - All other information that follows in this chapter, unless otherwise noted
- Information (including references to applicable appendices) specified as applying to self-insured medical plan options in "Chapter 1: Eligibility, Enrollment, and More"

Providers and provider networks

Providers

All providers must be licensed or certified under state law to practice in the state or territory in which they are providing services and must be acting within the scope of their licensure or certification.

Some providers, at their discretion, may require you to pay the fee or a portion of the fee for services upfront.

Ineligible providers

The following providers are considered ineligible providers for all claims administrators:

- An unlicensed provider or a provider who is operating outside of the scope of their license or certification
- A provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child, including any service the provider may perform on themself
- A provider with the same legal residence as the patient

Provider networks

Enrollment in a medical plan does not guarantee the availability of any particular physician within the applicable claims administrator's associated network. Your claims administrator's network may change throughout the year; new providers may be added and others may discontinue their participation in the applicable claims administrator's associated network. You are responsible for verifying the network status of your providers for every service you receive.

For the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, and Flex HDHP, the claims administrators each have a broad network. You have the choice to see any provider for most covered health services, and no referrals are required to see a specialist. However, it is recommended that you have a primary care physician (PCP) whom you see regularly and who can coordinate your care. Depending on your location, you may be able to receive services from in-network providers.

And when you travel, if you need to see a provider while in another state, or if you have dependents living out of state, you may have in-network providers available to you throughout the U.S. Contact your claims administrator for information about the availability of in-network providers in a specific area. When you receive services from an in-network provider, you can take advantage of negotiated reimbursement rates. In addition, the plan will pay a greater percentage of the cost of covered health services received from in-network providers after you've met the annual deductible.

If you enrolled in one of these three broad network plan options and your home ZIP code is outside the network service area for your state's claims administrator, you will have Out of Area coverage. If your home ZIP code is within the network service area for your state's claims administrator, you are not eligible for Out of Area coverage. If you are eligible for Out of Area coverage, this indicates there are few, if any, network providers in your area. Under Out of Area coverage, the applicable cost-sharing is the same regardless of whether you receive services from an in-network or out-of-network provider.

For the Narrow Network Copay Plan and the Narrow Network Plan with HSA, there is no broad network, only a narrow specific network determined by the claims administrator. You are required to go to an in-network provider associated with the specific network for your plan and geographic area (except for emergency services). Also depending on your plan's network, you may be required to designate a primary care physician (PCP) and obtain a referral from your PCP before you can receive services from a specialist. For more information, see the specific information in claims administrator sections that follow.

Under these two narrow network plan options, you do not have out-of-network coverage (except for emergency services) and there is no Out of Area coverage. If you are traveling or use providers outside your network service area or in another state, or have dependents living out of state, there is no coverage available. Contact your claims administrator for network providers in your area.

UnitedHealthcare provider networks

To determine if UnitedHealthcare is your claims administrator, refer to the "Medical plans by location" starting on page 2-5.

Network providers are the participating licensed medical professional providers and facilities that have entered into an agreement with UnitedHealthcare to provide health care services to covered members.

Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, and Flex HDHP – UHC

The UnitedHealthcare Choice Plus Network is the broad network of providers associated with the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, and Flex HDHP administered by UnitedHealthcare. With the broad network, you can see any UnitedHealthcare Choice Plus Network provider nationwide and receive in-network benefits.

You can identify Choice Plus Network providers at myuhc.com.

Narrow Network Copay Plan and Narrow Network Plan with HSA – UHC

These narrow network plans have a smaller local area network of providers. To receive benefits under these plans, you must see a provider in your specified local area network (see more information below). Generally, you will not receive benefits if you receive services from a provider outside your local area network, unless you have a medical emergency (see the "Emergency care" section below for more information).

You can identify your local area in-network providers at myuhc.com.

- **In Minnesota (Minneapolis/St. Paul Metro area)**, the UnitedHealthcare Fairview ACO Network (part of the UnitedHealthcare Core Network), is the local area network of providers associated with the Narrow Network Copay Plan and Narrow Network Plan with HSA. You are not required to designate a primary care physician (PCP) at enrollment, but it's recommended that you establish a medical care relationship with a Fairview ACO Network PCP. After you enroll, a representative from the Fairview ACO Network will reach out to you to ask who you choose as your PCP.
- **In Illinois (Chicago Metro area)**, the UnitedHealthcare Charter Network ("Charter Network") in the Chicago area is the local network of providers associated with the Narrow Network Copay Plan and Narrow Network Plan with HSA. You are required to designate a Charter Network primary care physician (PCP) in the Chicago area — see "Electing a Charter Network PCP" below for more information.

  Your Charter Network PCP is the key to your benefits. Generally, you must obtain a referral from your PCP before seeing another network provider (including other in-network PCPs); specialists may not provide referrals to other specialists. You may, however, self-refer to an in-network OB/GYN, mental health/substance abuse provider, nurse practitioner, physician assistant, or optometrist within your local area network.

  Electing a Charter Network PCP

  – Each person enrolled (member) must select a Chicago area Charter Network PCP at the time of enrollment. This also applies to students who may be living away from home or children living with another parent. Each family member may select a different PCP within the network.

  – If a member doesn't select a Charter Network PCP at the time of enrollment, UHC will assign one using a randomized selection process.

  Changing your Charter Network PCP (post enrollment)

  – PCP changes may be requested by the member by calling Customer Service at the toll-free number on their member ID card or by visiting myuhc.com. Changes are allowed only once per month.

  – PCP changes submitted between the 1st and 31st of the month will become effective the first of the next month.

  – Once a member changes their PCP, a new member card will be generated. The member should receive it within seven to 10 days. They will be able to view the image of the new card reflecting the new PCP within 48 to 72 hours on myuhc.com.

- **For both Minnesota and Illinois, if you need services when outside your local network service area**

  – **Emergency care**

  If you or a covered family member has a medical emergency, seek the services needed to avoid jeopardy to life or health. Emergency care received in a hospital emergency room facility is covered (see the "Emergency care" starting on page 2-72 for more information). If hospitalization is required, you or a family member must contact UnitedHealthcare as soon as possible at 1-800-842-9722 to obtain authorization (see "Urgent care claims (and concurrent care claims)" starting on page 2-141 for more information).

  – **Non-emergency care**

  If you or a covered family member are outside your local network service area and need non-emergency medical services, generally, **you will not receive benefits for services received from an out-of-network provider**. However, if you contact UnitedHealthcare at 1-800-842-9722 before receiving services, they may be able to direct you to an associated network urgent care or convenience care clinic in your current location or to a provider within the virtual provider network.

  - **If you are enrolled in Minnesota with the Minneapolis/St. Paul area Fairview ACO Network**, and you are outside your local network service area, you may receive services from a UnitedHealthcare Core Network provider and still receive benefits under the Plan.
  - **If you are enrolled in Illinois with the Chicago area Charter Network**, for a covered student dependent who is away at school, the student's designated network PCP can provide an authorized referral to another Charter network provider where the student lives (the referral authorization must be received before services are provided). A new authorized referral is required for each visit.

Anthem BCBS provider networks

To determine if Anthem BCBS is your claims administrator, refer to the "Medical plans by location" starting on page 2-5.

Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, and Flex HDHP – Anthem

The BlueCard PPO is the provider network for the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, and Flex HDHP. In addition, employees at certain locations have access to clinics in or near their assigned work location. This includes the Atrium Health North Charlotte Medical Specialists – University for employees whose work location is at the Customer Information Center in Charlotte, N.C. and The Health Center at Hudson Yards for employees whose work location is in the 30 Hudson Yards building in New York City, N.Y. Since a provider's participation with your claims administrator's network can change, you should confirm with your provider prior to service that the provider is participating in your claims administrator's network.

You may identify in-network providers at anthem.com.

Narrow Network Copay Plan and Narrow Network Plan with HSA – Anthem

These narrow network plans have a smaller network of providers. To receive benefits under these plans, you must see a provider in your specified network (see more information below). Generally, you will not receive benefits if you receive services from a provider outside your network, unless you have a medical emergency (see the "Emergency care" bullet below for more information).

Anthem's Blue High Performance Network (Blue HPN) is the network of providers associated with the Narrow Network Copay Plan and Narrow Network Plan with HSA, administered by Anthem. The specific narrow networks for each region are noted below. You are not required to designate a primary care physician (PCP), but it's recommended that you establish a medical care relationship with an in-network PCP.

- Missouri (St Louis Metro Area): Blue High Performance Network (Blue HPN)
- North Carolina (Charlotte, Concord-Gastonia Metro Area): Blue High Performance Network (Blue HPN)

You can identify in-network Blue High Performance Network (Blue HPN) providers at anthem.com. If you travel outside of your local home Blue HPN area, please contact Anthem at the number on your ID card for more information (1-866-418-7749).

If a Blue High Performance Network (Blue HPN) member travels to a city where a Blue HPN solution is not available, they would generally only have access to urgent and emergency care. If you need services when outside your Blue HPN service area:

- **Emergency care**

  If you or a covered family member has a medical emergency, seek the services needed to avoid jeopardy to life or health. Emergency care received in a hospital emergency room facility is covered (see the "Emergency care" starting on page 2-72 for more information). If hospitalization is required, you or a family member must contact Anthem as soon as possible at 1-866-418-7749 to obtain authorization (see the "Urgent care claims (and concurrent care claims)" starting on page 2-141 for more information).

  Non-emergency care

  If you or a covered family member are outside your network service area and need non-emergency medical services, generally, **you will not receive benefits for services received from an out-of-network provider**. If you travel outside of your home network area, please contact Anthem at the number on your ID card for more information (1-866-418-7749). Anthem may be able to assist you with locating participating providers.

Aetna provider networks

To determine if Aetna is your claims administrator, refer to the "Medical plans by location" starting on page 2-5. Network providers are the participating licensed medical professional providers and facilities that have entered into an agreement with Aetna to provide health care services to covered members.

Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, and Flex HDHP – Aetna

The Aetna Choice POSII is the broad network of providers associated with the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, and Flex HDHP administered by Aetna. With the broad network, you can see any Aetna Choice POSII network provider nationwide and receive in-network benefits. In addition, employees at certain locations have access to clinics in or near their assigned work location. This includes The Health Center at Hudson Yards for employees whose work location is in the 30 Hudson Yards building in New York City, N.Y. Since a provider's participation with your claims administrator's network can change, you should confirm with your provider prior to service that the provider is participating in your claims administrator's network.

You can identify Aetna Choice POSII providers at aetna.com.

Narrow Network Copay Plan and Narrow Network Plan with HSA – Aetna

These narrow network plans have a smaller local area network of providers. To receive benefits under these plans, you must see a provider in your specified local area network (see more information below). Generally, you will not receive benefits if you receive services from a provider outside your local area network, unless you have a medical emergency (see the "Emergency care" bullet below for more information).

Aetna's Whole Health networks (AWH) and Joint Ventures are the network of providers associated with the Narrow Network Copay Plan and Narrow Network Plan with HSA, administered by Aetna. The specific narrow networks for each region are noted below. You are not required to designate a primary care physician (PCP), but it's recommended that you establish a medical care relationship with an in-network PCP.

- Arizona (Phoenix area) — Banner | Aetna Joint Venture network
- Iowa (Des Moines area and certain other IA locations) — UnityPoint Accountable Care Network

- Texas (Dallas/Fort Worth area) — Texas Health Aetna Joint Venture network
- Texas (Houston area) — AWH ACO Memorial Hermann network
- Texas (San Antonio area) — AWH ACO Quality Partners in Health/Baptist Health network

You can identify local area AWH and Joint Venture in-network providers at aetna.com. If you travel outside of your local home network area, contact Aetna at the number on your ID card for more information.

If you need services when outside your local Aetna AWH or Joint Venture network service area

- **Emergency care**

  If you or a covered family member has a medical emergency, seek the services needed to avoid jeopardy to life or health. Emergency care received in a hospital emergency room facility is covered (see the "Emergency care" starting on page 2-72 for more information). If hospitalization is required, you or a family member must contact Aetna as soon as possible at 1-877-320-4577 to obtain authorization (see "Urgent care claims (and concurrent care claims)" on page 2-141 for more information).

- **Non-emergency care**

  If you or a covered family member are outside your local network service area and need non-emergency medical services, generally, **you will not receive benefits for services received from an out-of-network provider**. However, when you are outside the Aetna network designated for your local area (as noted above), enrolled members can access convenience care clinics and use Aetna's virtual provider network. For more information about these providers, contact Aetna at the number on your ID card before receiving services.

Important terms

Annual deductible

The annual deductible is the amount that you must pay under the Wells Fargo & Company Health Plan toward the eligible expenses for applicable covered health services before the medical plan begins to pay any portion of the cost of eligible expenses for those covered health services.

If you cover dependents, expenses for all covered members accrue toward the applicable level of coverage annual deductible. The annual deductible can be met by one covered member or any combination of covered members.

The annual deductible is applied to the annual out-of-pocket maximum. The in-network and out-of-network annual deductibles and annual out-of-pocket maximums do not accumulate jointly. Therefore, charges for services in-network do not count toward your out-of-network annual deductible and annual out-of-pocket expenses and vice versa.

The annual deductible will be adjusted for midyear level of coverage election changes. For more information, see the applicable section:

- "How the Copay Plan with HRA works" section starting on page 2-13
- "How the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, and Flex HDHP work" section starting on page 2-23
- "How the Narrow Network Copay Plan works" section starting on page 2-32

The annual deductible is referred to as "deductible" in the cost-sharing tables starting on page 2-54 .

The following do not count toward the annual deductible:

- Copays for prescription drugs and for the Copay Plan with HRA and Narrow Network Copay Plan copays for these in-network services: a PCP office visit, a mental health or substance abuse provider office visit, a specialist office visit, a telemedicine consultation, a convenience care visit (in retail settings), certain treatments, or an urgent care visit
- Charges for services that are not covered under the plan
- Charges in excess of the eligible expense, including amounts in excess of the allowed amount, balance billed by out-of-network providers
- The reduction amount applied that resulted from the failure to follow the pre-service authorization procedures that would otherwise be payable for eligible covered health services
- Prescription drug copays and costs
  - Charges for the difference in cost between a generic drug and a brand-name drug if a brand-name drug is selected when a generic is available
  - Out-of-network prescription drug charges for the difference in cost between the full cost and the Express Scripts discounted amount
- Manufacturer assistance for prescription drugs does not apply toward your deductible and out-of-pocket maximums. See the "Manufacturer assistance programs/out-of-pocket protection program" section on page 2-148 for more information

Annual out-of-pocket maximum

The annual out-of-pocket maximum is generally the most you pay during the plan year under the Wells Fargo & Company Health Plan before the medical plan begins to pay 100% of the eligible expense for covered health services, subject to certain limitations described below. The annual out-of-pocket maximum includes the annual deductible, copays, and the per plan year coinsurance.

If you cover dependents, eligible expenses for all covered members accrue toward the applicable level of coverage annual out-of-pocket maximum. The out-of-pocket maximum is not required to be met by each covered member. The out-of-pocket maximum can be met by any combination of covered members or by an individual covered member. The in-network and out-of-network annual out-of-pocket maximums do not accumulate jointly. Therefore, charges for services in-network

do not count toward your out-of-network annual out-of-pocket expenses and vice versa.

The annual out-of-pocket maximum will be adjusted for midyear level of coverage election changes. For more information, see the applicable section:

- "How the Copay Plan with HRA works" section starting on page 2-13
- "How the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, and Flex HDHP work" section starting on page 2-23
- "How the Narrow Network Copay Plan works" section starting on page 2-32

The following do not count toward the annual out-of-pocket maximum:

- Charges for services that are not covered under the plan
- Charges in excess of the eligible expense, including amounts in excess of the allowed amount, balance billed by out-of-network providers
- The reduction amount applied that resulted from the failure to follow the pre-service authorization procedures that would otherwise be payable for eligible covered health services
- Charges for the difference in cost between a generic drug and a brand-name drug if a brand-name drug is selected when a generic is available
- Out-of-network prescription drug charges for the difference in cost between the full cost and the Express Scripts discounted amount

Individual out-of-pocket maximum

Under the individual out-of-pocket maximum, no one individual will be required to pay more than $8,700 in annual in-network, out-of-pocket expenses before the plan begins to pay 100% of covered eligible expenses. This individual maximum applies when the annual out-of-pocket maximum for the elected level of coverage exceeds $8,700.

- For the Lower Use Plan with HSA and Flex HDHP, when the applicable level of coverage has an in-network annual out-of-pocket maximum higher than $8,700, no one individual will pay more than $8,700 in combined eligible covered medical and prescription drug expenses for the in-network annual out-of-pocket maximum.
- For the Lower Use Plan with HSA Out of Area and Flex HDHP Out of Area coverage when the applicable level of coverage has an annual out-of-pocket maximum higher than $8,700, no one individual will pay more than $8,700 in eligible covered medical expenses (received from in-network and out-of-network providers combined) combined with in-network prescription drug eligible expenses for the annual out-of-pocket maximum.

Coinsurance

Coinsurance is the amount you pay toward eligible expenses for covered health services, generally after you have met the deductible, which is typically expressed as a percentage of the eligible expense.

The amount of coinsurance you are required to pay may vary depending on whether you receive services from an in-network provider or an out-of-network provider and which medical plan you are enrolled in. You must meet the annual deductible before the coinsurance applies for all services unless specifically noted otherwise in this SPD. See the "What the medical plans cover" section starting on page 2-50 and the "Prescription drug benefit" section starting on page 2-146.

Copay

The copay is a fixed dollar amount you pay toward eligible expenses for certain covered health services such as a physician office visit or prescription drugs.

Copays generally must be paid to the provider at the time you receive the service. See the cost-sharing charts in the "Services covered under the medical plans" section starting on page 2-53, the corresponding cost-sharing tables starting on page 2-54, and the "Prescription drug benefit" section starting on page 2-146 for services subject to a copay. For the Copay Plan with HRA and the Narrow Network Plan with HRA, you do not need to meet the annual deductible before the copay applies. But for the Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, and Flex HDHP, you will need to meet the annual deductible before prescription drug copays apply unless your prescribed drug is on the preventive drug therapy list.

Plan year

The plan year is the same as the calendar year, beginning on January 1 and ending the following December 31.

How the Copay Plan with HRA works

The Copay Plan with HRA has an associated health reimbursement account (HRA) to help you pay for eligible expenses for covered health services. For more information, see the "Health reimbursement account (HRA)" section starting on page 2-14, the "Covered health services definition" section starting on page 2-50, and the "Eligible expenses (allowed amount) definition" section starting on page 2-50. Below is additional information to help you understand how the plan works depending on whether you receive services from in-network or out-of-network providers.

- You pay a copay for certain services (prescription drugs, office visits, convenience care in a retail setting, telemedicine, and urgent care). You do not need to meet the annual deductible before the copay applies. Copays don't count toward the annual deductible. Refer to the "Services covered under the medical plans" section starting on page 2-53 and the corresponding cost-sharing tables starting on page 2-54 for more specific information on when copays apply to medical services. Refer to the "Prescription drug benefit" section starting on page 2-146 for information about what you will pay for prescription drugs.

- You pay 100% of eligible expenses for non copay covered health services until you satisfy the applicable annual deductible, except as otherwise noted in the cost-sharing tables starting on page 2-54, and in the "Prescription drug benefit" section starting on page 2-146.
- After you satisfy the applicable annual deductible:
  - For in-network and Out of Area coverage, you will typically pay 20% coinsurance for your share of eligible expenses for most covered health services received.
  - For out-of-network services, you will typically pay 50% coinsurance for your share of eligible expenses for most covered health services.
  - For prescription drugs, you will pay the applicable copay.

  Refer to the "Services covered under the medical plans" section starting on page 2-53 and the corresponding cost-sharing tables starting on page 2-54 for more specific information on in-network, out-of-network, and Out of Area coverage cost-sharing percentages and other requirements for covered health services.
- Prescription drug copays apply regardless of whether or not you have met the annual deductible for medical services. Refer to the "Prescription drug benefit" section starting on page 2-146 for information about what you will pay for prescription drugs.
- For certain covered health services (or prescription drugs) not subject to the annual deductible, the applicable copay or coinsurance does not count toward the annual deductible, but it does count toward the annual out-of-pocket maximum.
- After you satisfy the applicable annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services (for example, if you have met the in-network annual out-of-pocket maximum, the plan will pay 100% of eligible covered expenses for covered health services from an in-network provider for the remainder of the year, but it would not pay 100% of eligible expenses for covered health services received from an out-of-network provider until the out-of-network annual out-of-pocket maximum has been met).
- Additional information about services received from in-network providers:
  - The in-network provider should request any required pre-service authorizations for you. However, it's your responsibility to ensure that the necessary pre-service authorizations have been received before services are provided. For more information, see the "Pre-service authorization requirements" section starting on page 2-45.
  - The in-network provider will file claims for you.
  - You pay 100% for services and expenses not covered by the medical plan; however, you are generally not responsible for any charges the in-network provider must write off as a result of its contract with the claims administrator or the claims administrator's associated networks.

  For more information on in-network providers, see the "Providers and provider networks" section starting on page 2-9.
- Additional information about services received from out-of-network providers:
  - You must contact the claims administrator to receive required pre-service authorizations for certain services (see the "Pre-service authorization requirements" section starting on page 2-45) before receiving those services from an out-of-network provider.
  - You may be required to pay the out-of-network provider and file claims for reimbursement (see the "Claims and appeals" section starting on page 2-141 for more information). If the out-of-network provider files claims for you, you are responsible for ensuring the provider follows the plan's claims filing requirements, including filing a claim within 12 months from date of service.
- You pay 100% for expenses above those considered eligible expenses by the plan. An out-of-network provider can bill you for all expenses the plan does not cover, including those above the eligible expense (or allowed amount), and you are responsible for payment to the out-of-network provider. The difference between the out-of-network provider's billed charges and the eligible expense (allowed amount) is not applied toward the annual deductible or annual out-of-pocket maximum and is your responsibility. This applies to all out-of-network services described in this SPD chapter, including Out of Area coverage.
- You pay 100% for services and expenses not covered by the medical plan.

Health reimbursement account (HRA)

If you enroll in the Copay Plan with HRA, you and your covered spouse or domestic partner can have amounts allocated to your HRA by completing certain health- and wellness-related activities. Refer to the "Health and wellness activities" section starting on page 2-37.

The HRA is a notional bookkeeping entry, and no specific funds will be set aside in an account (or otherwise segregated) for purposes of funding an HRA. No interest or earnings will be credited to an HRA. Amounts allocated to an HRA are not vested and are subject to forfeiture. Wells Fargo & Company reserves the unilateral right to amend or modify the HRA at any time for any reason, with or without notice, including placing limitations or restrictions on amounts allocated to an HRA or terminating the HRA.

You can use the available balance in your HRA to pay for eligible expenses. If you don't use all of your HRA dollars and you remain enrolled in the Copay Plan with HRA in the following year, any remaining HRA dollars will roll over, and will be available for you to use the following year for eligible expenses incurred while you are enrolled in the Copay Plan with HRA and filed within the claims filing period, subject to any limitations that may be imposed under the plan.

For more information about HRA dollars, refer to the "Copay Plan with Health Reimbursement Account (HRA): Annual deductible and annual out-of-pocket maximum" table on page 2-22.

HRA dollars are subject to all of the following restrictions:

- You can use your HRA dollars to pay for eligible medical and pharmacy expenses, including copays. For more information, see the "Using your HRA dollars" section on page 2-15.
- HRA dollars are not considered to be available for eligible expenses for covered health services until the HRA dollars have been allocated to your HRA.
- HRA dollars may only be used to pay for covered health services after the health and wellness activities have been completed and the associated dollars have been allocated to your HRA.
- You will forfeit all amounts allocated to your HRA if your employment is terminated for any reason (or you are no longer eligible for the Copay Plan with HRA) and you do not elect COBRA continuation coverage in the Copay Plan with HRA.
- You will forfeit all amounts allocated to your HRA if you terminate employment and are eligible to elect retiree medical plan coverage but do not elect the HRA-Based Medical Plan under the Wells Fargo & Company Retiree Plan ("Retiree Plan"), or if you are eligible for Medicare.
- You will forfeit all amounts allocated to your HRA if your Copay Plan with HRA coverage is terminated or waived for any reason at any time (including a gap in coverage during the year, even if you reenroll again later in the year).
- HRA dollars are a plan design feature, are not portable, and are not a guaranteed benefit.

If you are enrolled in the Copay Plan with HRA in 2022, you can keep track of the available balance in your HRA by going online to **https://participant.wageworks.com** or by calling the number on the back of your HealthEquity Healthcare Card.

Using your HRA dollars

If you are enrolled in the Copay Plan with HRA, your HRA dollars are administered by HealthEquity. To use your available HRA dollars, you need to submit eligible medical and pharmacy expenses for payment or reimbursement from your available HRA dollars as described in this section. You have 12 months from the end of the month you incur an eligible medical or pharmacy expense to submit that expense for payment or reimbursement from your HRA. For example, if you incurred an eligible medical or pharmacy expense on June 15, 2022, you would have until June 30, 2023, to submit the expense for payment or reimbursement. Expenses submitted after this deadline cannot be paid or reimbursed from the HRA.

When you are enrolled in the Copay Plan with HRA, you will automatically receive a HealthEquity Healthcare Card (Card). You can use the Card to pay for eligible medical and pharmacy expenses. The Card is generally accepted anywhere that healthcare products are sold, including pharmacies, drug stores, doctors' offices, hospitals, and online drug stores. You may also utilize available HRA dollars via the Pay Me Back or Pay My Provider methods (see the "Non-HealthEquity Healthcare Card HRA transactions" starting on page 2-16 for more information).

When you use your Card for payment of eligible expenses, funds are deducted from your HRA to pay for the purchase. (If you are also enrolled in the Full Purpose Health Care FSA, see the "Coordination of HRA and Full-Purpose Health Care FSA on the HealthEquity Healthcare Card" section on this page. If you are also enrolled in the Limited Dental/Vision FSA, see the "Coordination of HRA and Limited Dental/Vision FSA on the HealthEquity Healthcare Card" section on page 2-16) In some cases, when payments are made with the Card you will need to provide an explanation of benefits (EOB) and receipt to HealthEquity to support your use of HRA dollars. You should keep your EOBs and expense receipts for all expenses that you pay from available HRA dollars with your Card. If you do not provide an EOB and receipt when requested, your Card may be suspended and you may be asked to pay back the amount of the transaction.

Eligible HRA expenses

You can use your HRA dollars to pay for eligible medical and pharmacy expenses, including copays. An eligible expense is an expense covered by the Copay Plan with HRA medical plan for the participant, a covered spouse, covered domestic partner, or covered child. A list of eligible expenses can be accessed at **https://participant.wageworks.com**. HRA dollars cannot be used for dental or vision expenses, over-the-counter medicines, or medical or pharmacy expenses not covered by the Copay Plan with HRA. For example, HRA dollars cannot be used for medical or pharmacy expenses incurred by your spouse, domestic partner, or child who is not enrolled in the Copay Plan with HRA at the time the expense is incurred.

Coordination of HRA and Full-Purpose Health Care FSA on the HealthEquity Healthcare Card

If you are enrolled in a Full-Purpose Health Care Flexible Spending Account (FSA) and the Copay Plan with HRA in 2022, you will receive one Card to use with both accounts. There are rules regarding how your HRA and Full-Purpose Heatlh Care FSA balances will be applied to pay for eligible medical and pharmacy expenses.

- **When does the Full-Purpose Health Care FSA pay first?** The Full-Purpose Health Care FSA will pay first on eligible dental and vision expenses, over-the-counter medicines, and medical and prescription drug expenses not covered by the Copay Plan with HRA. These expenses cannot be paid from available HRA dollars and will automatically be paid from the available Full-Purpose Health Care FSA balance. **Note:** If you have Full-Purpose Health Care FSA-eligible dependents who are not enrolled in the Copay Plan with HRA, you cannot use your Card to pay for their eligible medical and pharmacy expenses with your Full-Purpose Health Care FSA until HRA funds are completely exhausted. Instead, you can use your Full-Purpose Health Care FSA balance for these expenses by utilizing the Pay Me Back or Pay My Provider methods.
- **When does the HRA pay first?** If you have HRA funds available, these funds will pay first for all eligible medical and pharmacy expenses covered by the Copay Plan with HRA.

When HRA funds are completely exhausted, any available Full-Purpose Health Care FSA balance will then be applied to these expenses.

Coordination of HRA and Limited Dental/Vision FSA on the HealthEquity Healthcare Card

If you are enrolled in a Limited Dental/Vision Flexible Spending Account (FSA) and the Copay Plan with HRA in 2022, you will receive one Card to use with both accounts.

- **When does the Limited Dental/Vision FSA pay?** The Limited Dental/Vision FSA will pay for eligible dental and vision expenses.
- **When does the HRA pay?** Available HRA funds will pay for all eligible medical and pharmacy expenses covered by the Copay Plan with HRA.

Keep receipts and explanations of benefits (EOBs)

Keep your expense receipts and EOBs. HealthEquity may contact you to submit an EOB or receipt to verify that an expense is eligible. If you are not able to produce an EOB and/or receipt for an expense, your Card may be suspended, and you may be asked to pay back the amount of the transaction.

If there are Card transactions that require your attention, you will be notified when you access your account online. **Access your account at https://participant.wageworks.com regularly to see if you have any Card transactions that need verification**.

Due to the time sensitivity of the Card verification requests, it is strongly recommended that you provide your email address to HealthEquity by accessing your account and updating your profile. Your prompt attention is required to resolve any amount that requires substantiation. HealthEquity is required to ensure HRA funds are used only for eligible products and services, and that any ineligible payments or expenses are not paid or reimbursed. If such receipts and/or EOBs aren't sent in the time frame indicated by HealthEquity, your Card may be suspended until the issue is resolved. If your Card is suspended, see the "Card suspensions" starting on page 2-17 for more information.

Terminating coverage in the Copay Plan with HRA

If your medical coverage in the Copay Plan with HRA terminates, you will not be able to use your Card after your coverage termination date to access any remaining HRA balance. HealthEquity will retain your HRA balance for 12 months following the date your coverage terminates to allow you to use available HRA dollars for eligible claims incurred on or before your medical coverage termination date via the Pay My Provider or the Pay Me Back methods (described in the "Non-HealthEquity Healthcare Card HRA transactions" section below).

If your medical coverage in the Copay Plan with HRA terminates under COBRA, HealthEquity will retain your HRA balance for 12 months following the date your coverage terminates to allow you to use available HRA dollars for eligible claims incurred on or before your COBRA medical coverage termination date via the Pay My Provider or the Pay Me Back methods (described in the "Non-HealthEquity Healthcare Card HRA transactions" section below).

Additional, stolen, and replacement Cards

You may receive additional HealthEquity Healthcare Cards for a spouse or adult-aged (18 or older) eligible dependent by visiting **https://participant.wageworks.com** , or by contacting HealthEquity customer service at 1-877-924-3967. When your dependent is no longer eligible, you must cancel the Cards for your dependents by calling HealthEquity customer service.

You are responsible for promptly notifying HealthEquity if the Card is lost or stolen.

You can request a replacement HealthEquity Healthcare Card online on the member website or by contacting HealthEquity customer service at 1-877-924-3967.

Non-HealthEquity Healthcare Card HRA transactions

If you incurred eligible expenses and did not use your Card to pay for them, you have multiple options for utilizing HRA dollars. The Pay My Provider method of payment can be utilized when you want to request that a bill for an eligible expense be paid directly to a provider from available HRA funds. Pay My Provider can be utilized on the HealthEquity website or mobile app. This app should be used on personal devices only and should not be used on Wells Fargo owned devices.

The Pay Me Back method can be utilized if you paid the provider with your personal funds and want to be reimbursed for the eligible expense from available HRA funds. You can submit Pay Me Back claims within 12 months from the end of the month you incur an eligible medical or pharmacy expense in one of the following ways:

- Using the website, you can complete an online claim form at **https://participant.wageworks.com**, and upload your scanned supporting expense documentation for your claim submission. This documentation may include, but is not limited to, a receipt and/or explanation of benefits (EOB).
- You can use the HealthEquity mobile app. It's a quick and easy way to submit claims and receipts. This app should be used on personal devices only and should not be used on Wells Fargo owned devices.
- You can fax a completed and signed claim form along with all required supporting expense documentation to HealthEquity at 1-877-353-9236 (keep a copy of the faxed documentation and the fax confirmation).
- You can mail the completed and signed claim form, along with all required supporting expense documentation, to:

  HealthEquity
  Claims Department
  PO Box 14053
  Louisville, KY 40512

You can download a claim form from **https://participant.wageworks.com.**

All claim forms should be submitted with the following information and the applicable supporting expense documentation:

- Date service was provided

- Type or description of service provided
- Name of the service provider
- Name of the patient/dependent
- Amount of the expense incurred

You will be reimbursed for claims the same way you receive your pay. If you receive your pay by direct deposit, your reimbursement will be deposited to the same account (if you have more than one direct deposit account, your reimbursement will be deposited into the balance account). If you receive your pay by check, you'll receive your reimbursement by check.

Ineligible payments or reimbursements

If you use your Card to pay for eligible expenses and later receive an adjustment due to an overpayment, you will be required to pay back the ineligible payment amounts to HealthEquity for credit to the HRA. HealthEquity will contact you for more information about the expense in question and with options for resolving the issue. Your options for repayment for the HRA are either:

- The provider can send a refund directly to you. You would then need to remit payment back to HealthEquity.
- The provider can return funds to the Card used to pay for the service. In this case, it would increase your balance accordingly.

If you use your Card to pay for ineligible expenses, you will be required to pay back the improper payment amounts to HealthEquity for credit to the HRA.

If you fail to make this repayment, Wells Fargo may withhold the amount of the improper payment from your wages or other compensation to the extent consistent with applicable law. The Health Plan or HealthEquity may also withhold making reimbursements on future valid claims until the amount due to be repaid is recovered. Your Card will be suspended; you will not be able to use your Card until all repayments due are made; and you may be subject to corrective action, including termination of your employment. For information on resolving Card suspensions, see the "Card suspensions" starting on this page.

Questions, denied reimbursement, and appeals

If you have a question or concern about an expense or claim processed by HealthEquity, you can check your "Account activity and status" or you may call HealthEquity at 1-877-924-3967.

If your claim was denied (in whole or in part), you may also file a formal written appeal with HealthEquity. If you call HealthEquity, your call will not be considered a formal appeal under the terms of the plan. A formal written appeal must be filed with HealthEquity within 180 days of the date your claim is denied regardless of any verbal discussions that have occurred regarding your claim. More detailed information on the appeal process is provided in "Appendix A: Claims and Appeals."

Account activity and status

To check your balance and account activity 24 hours a day, 7 days a week, access your account online at **https://participant.wageworks.com** or call HealthEquity at 1-877-924-3967.

Your account activity and status includes information about:

- Your current available funds
- Your recent payments, claims, and reimbursements
- Payments requiring additional review and action
- Special messages about your account

Make sure to review your account activity and status thoroughly. If you have entered your preferred email address on the HealthEquity website, HealthEquity will provide you with critical activity-based email alerts, such as the claims payment and Card use verification notices.

The different statuses for each of your Card transactions are:

- **Pending**. HealthEquity is in the process of collecting information about this Card transaction from various sources and possibly the merchant. If HealthEquity is able to obtain information to verify this Card transaction paid for eligible products and services, you will not be required to submit a receipt, other documentation, or a repayment. If not, the status of this transaction will need to be updated to reflect documentation or repayment needed. In any case, be sure to save your EOBs and receipts with your important tax documents for the year.
- **No (Further) Action Required**. HealthEquity was able to resolve this amount without further action required from you, based on information available to HealthEquity from an EOB, receipt, other documentation, or a repayment you submitted.
- **Receipt or Repayment Needed**. HealthEquity was not able to verify that the amount of the Card transaction was used to pay for eligible products and services. You are now required to submit an EOB or other documentation that describes exactly what you paid for or repay the HRA for the expense. Pay Me Back claims received before verification of a transaction that is over 90 days old will be applied to the outstanding amount of the Card transaction first and then to pay any remaining balance. Refer to the Card Use Verification Form for more information about your options to resolve this amount.
  - **See Card Use Verification Form** (instructions). If you have a Card transaction that requires verification, a link to the Card Use Verification Form will be prominently displayed when you access your account at https://participant.wageworks.com. The Card Use Verification Form contains a list of options to resolve an unverified Card payment from your account. Use this form to submit the actual receipt or a substitute receipt to show that this amount was used for eligible products and services or to submit a check to repay your account for this amount.

Card suspensions

If HealthEquity is unable to determine that a Card transaction was used for eligible expenses, HealthEquity will ask you to submit a Card Use Verification Form. If HealthEquity does not receive the form with all required documentation within 90 days of the transaction, your Card will be suspended and the amount will be deducted from your next requested Pay Me Back reimbursement check. Card suspensions can be resolved by one of the following methods:

1. Providing verification of the original expense.

2. Providing verification for a substitute expense that occurred in the same period and has not already been reimbursed.
3. Reimbursing the HRA for the amount of the original expense.

Reimbursements can be made by repaying your account on the HealthEquity Participant Site, personal check, money order, or your personal bank's online bill pay system. In order to make sure that your repayment gets posted to the correct account, make sure that account documentation is included on your check, money order, or online bill pay.

Card suspensions carry over from year to year. If your Card is suspended due to a prior year's expense, your current year's expenses cannot be used to offset the prior year's expense. In addition, while your Card is suspended, the Pay Me Back claim option is your only option for using your HRA account.

HRA dollars, annual deductible, and annual out-of-pocket maximum for midyear enrollments

If you enroll midyear in the Copay Plan with HRA, you are required to meet the full year annual deductible and annual out-of-pocket maximum, regardless of your effective date of coverage. However, the amount of health and wellness dollars that you and your covered spouse or domestic partner can earn will be prorated. For example, if you enroll midyear with coverage effective July 1 at the you-only level of coverage, for the remainder of this plan year at this level of coverage the following would apply:

- In-network annual deductible of $1,000
- In-network annual out-of-pocket maximum of $3,500
- Eligible to earn up to $400 in health and wellness dollars

Expenses incurred in a previous plan year or before the effective date of medical coverage under the Health Plan do not count toward the annual deductible or the annual out-of-pocket maximum. If you enroll in the Copay Plan with HRA mid-year as the result of changing from another medical plan option under the Health Plan (without a gap in coverage), amounts applied to your deductible or out-of-pocket maximum for the current plan year under the previous medical plan option will transfer to the Copay Plan with HRA. If you are changing from a Kaiser medical plan option to the Copay Plan with HRA, you must provide your (and if applicable, your dependent's) most recent current year's Kaiser explanation of benefits (EOB) statement to your new claims administrator in order for the current year's annual deductible and out-of-pocket maximum accumulations to transfer from Kaiser to the Copay Plan with HRA. If you are changing from one of the other Health Plan medical plan options, you do not need to provide your EOB statement; it will be updated automatically.

The information above applies to an employee's midyear enrollment in the Copay Plan with HRA. The information above also applies to a covered dependent of an employee who enrolls in the Copay Plan with HRA midyear as a COBRA-qualified beneficiary. The information above does not apply to certain rehired retirees (see the "Rehired retirees" section starting on this page).

Rehired COBRA participants

This section applies to you if you are an employee who is rehired by Wells Fargo and you had COBRA medical coverage under the Health Plan ("Health Plan") immediately preceding your rehire date.

If you had continuous COBRA medical coverage and you enroll in the Copay Plan with HRA as a rehired employee with no lapse in coverage, your HRA dollars earned under the Health Plan will be prorated. However, your annual deductible and annual out-of-pocket maximum are not prorated, regardless of the level of coverage elected. For example, if, as a COBRA participant, you were enrolled in the you-only level of coverage in the Copay Plan with HRA and, as a rehire, you enroll in the Copay Plan with HRA with coverage effective July 1 at the you-only level of coverage, for the remainder of this plan year at this level of coverage, the following would apply:

- In-network annual deductible of $1,000
- In-network annual out-of-pocket maximum of $3,500
- Eligible to earn up to $400 in health and wellness dollars for health and wellness activities that have not previously been completed during the plan year

As a rehired employee who had continuous medical COBRA continuation coverage and enrolled in the Copay Plan with HRA during a rehire enrollment period, the following will be applied to your Copay Plan with HRA coverage:

- Any unused HRA dollars can continue to be used to pay for eligible medical and pharmacy expenses or services.
- Amounts previously applied to your current year's COBRA annual deductible and annual out-of-pocket maximum will apply to your new Copay Plan with HRA annual deductible and annual out-of-pocket maximum for the same plan year (for eligible expenses incurred by you or eligible dependents that you covered under COBRA medical coverage and who remain covered under the Copay Plan with HRA).
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.

Rehired retirees

Any reference to the Wells Fargo & Company Retiree Plan ("Retiree Plan") is for informational purposes only and the provisions of that plan are not part of any official plan provision under the Health Plan.

This section applies to you if you are a retiree who is rehired by Wells Fargo, you had retiree medical coverage under the Retiree Plan immediately preceding your date of rehire, and you elect the Copay Plan with HRA as a rehired employee.

Your Copay Plan with HRA coverage under the Health Plan is effective on your date of rehire. Your HRA dollars earned by completing certain health & wellness activities will be prorated as noted above. However, your annual deductible and annual out-of-pocket maximum are not prorated, regardless of the level of coverage elected. For example, if, as a rehired retiree, you enroll in the Copay Plan with HRA with coverage effective

July 1 at the you-only level of coverage, for the remainder of this plan year at this level of coverage the following would apply:

- In-network annual deductible of $1,000
- In-network annual out-of-pocket maximum of $3,500
- Eligible to earn up to $400 in health and wellness dollars

If you had retiree medical coverage under the HRA-Based Medical Plan under the Retiree Plan immediately preceding your date of rehire and elect the Copay Plan with HRA, the following will be applied to your Copay Plan with HRA coverage:

- Any unused HRA dollars can continue to be used to pay for eligible medical and pharmacy expenses or services.
- Amounts previously applied to your current year's retiree annual deductible and annual out-of-pocket maximum will apply to your new Copay Plan with HRA annual deductible and annual out-of-pocket maximum for the same plan year (for eligible expenses incurred by you or eligible dependents that you covered under the HRA-Based Medical Plan benefit option of the Retiree Plan and who remain covered under the Copay Plan with HRA).
  - Your current year's annual deductible and annual out-of-pocket maximum accruals under the Retiree Plan HRA-Based Medical Plan will be credited automatically toward the current year's annual deductible or annual out-of-pocket maximum, as applicable, for the Copay Plan with HRA under the Health Plan if your claims administrator for the Copay Plan with HRA is UnitedHealthcare.
  - If the claims administrator is Anthem BCBS or Aetna for your Copay Plan with HRA, and you want your current year's annual deductible and annual out-of-pocket maximum accruals under your HRA-Based Medical Plan retiree coverage to be credited toward your Copay Plan with HRA coverage, you will need to provide your last HRA-Based Medical Plan EOB from UnitedHealthcare to your new claims administrator. Your claims administrator will contact UnitedHealthcare to verify the accuracy of the EOB and ensure that coverage was continuous.
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.

If your retiree medical coverage under the Retiree Plan was a benefit option other than the HRA-Based Medical Plan, none of your previous expenses under the Retiree Plan will be credited toward the annual deductible or annual out-of-pocket maximum for the Copay Plan with HRA.

Note: If your retiree medical coverage under the Wells Fargo & Company Retiree Plan (Retiree Plan) immediately preceding your date of rehire is the UnitedHealthcare Medicare Advantage plan or the Kaiser Senior Advantage plan, your coverage under the Medicare Advantage option will end prospectively at the end of the month of your date of hire or as soon as administratively feasible, in accordance with CMS guidelines. This means you may have coverage under both the Retiree Plan and the Wells Fargo & Company Health Plan (Health Plan) for a short period of time. During any overlap period where you have coverage under both plans, the Health Plan is the primary plan. This means health care providers and pharmacies should submit claims first to the Health Plan and second to the Retiree Plan.

HRA dollars, annual deductible, and annual out-of-pocket maximum for midyear changes

If you experience a midyear Qualified Event (see the "Qualified Events" section in "Chapter 1: Eligibility, Enrollment, and More") or other status change during the plan year resulting in an allowable change to your level of coverage, the annual deductible and the annual out-of-pocket maximum will be adjusted to reflect the new level of coverage for the year. However, the annual deductible and annual out-of-pocket maximum amounts are not prorated; you are required to meet the full year annual deductible and annual out-of-pocket maximum regardless of your effective date of coverage during the year.

Expenses incurred in a previous plan year or before the effective date of medical coverage in the Wells Fargo & Company Health Plan do not count toward the annual deductible or the annual out-of-pocket maximum. Eligible expenses incurred by any individual who is no longer enrolled in your plan as a result of the Qualified Event will apply toward your adjusted annual deductible and adjusted annual out-of-pocket maximum for the remainder of the plan year. If you enroll in the Copay Plan with HRA medical plan option mid-year as the result of changing from another medical plan option under the Health Plan (without a gap in coverage), amounts applied to your deductible or out-of-pocket maximum for the current plan year under the previous medical plan option will transfer to the Copay Plan with HRA. If you are changing from a Kaiser medical plan option to the Copay Plan with HRA, you must provide your (and if applicable, your dependent's) most recent current year's Kaiser explanation of benefits (EOB) statement to your new claims administrator in order for the current year's annual deductible and out-of-pocket maximum accumulations to transfer from Kaiser to the Copay Plan with HRA. If you are changing from one of the other medical plan options, you do not need to provide your EOB.

When your level of coverage is increased due to a Qualified Event, any unused HRA dollars will remain in your HRA. If a person is added to your coverage who was previously enrolled in the Copay Plan with HRA and has any remaining HRA dollars, those HRA dollars do not roll over to your HRA when they are added to your coverage. Health and wellness dollars are prorated for a spouse or domestic partner who is added midyear based on their effective date of coverage. For example, if your spouse is added to coverage on July 1, they would only be eligible to earn up to $400 for completing all health and wellness activities during the plan year.

When your level of coverage decreases due to a Qualified Event, any unused HRA dollars will remain in your HRA.

If you elect another medical plan benefit option, any HRA dollars remaining at the time of the plan change will be forfeited.

COBRA enrollment

Former or ineligible employees who elect COBRA

If you are eligible for and elect COBRA continuation coverage for the Copay Plan with HRA during your initial COBRA enrollment period, any HRA dollars remaining on the date your coverage as an employee ended will continue to be available to help you pay for eligible covered expenses incurred while your Copay Plan with HRA COBRA continuation coverage is in effect.

If you elect the same level of coverage that you had under the Copay Plan with HRA as an employee and enroll the same dependents, covered expenses previously applied to the current year's annual deductible and annual out-of-pocket maximum for you and your covered dependents will apply to your Copay Plan with HRA COBRA continuation coverage for the same plan year. If you do not elect the same level of coverage you had under the Copay Plan with HRA as an employee, your annual deductible and annual out-of-pocket maximum will be adjusted (but are not prorated) and covered expenses previously applied to the current year's annual deductible and annual out-of-pocket maximum for you, and any dependents that you cover through COBRA, will apply to your Copay Plan with HRA COBRA continuation coverage for the same plan year.

Dependents who elect COBRA

If your covered dependent is no longer eligible for coverage under your Copay Plan with HRA coverage and elects COBRA continuation coverage under the Copay Plan with HRA, any charges that were incurred by the dependent and applied toward the current plan year annual deductible and annual out-of-pocket maximum before the dependent's last day of coverage will count toward the dependent's deductible and annual out-of-pocket maximum under their Copay Plan with HRA COBRA continuation coverage for the same plan year. Also see the "HRA dollars, annual deductible, and annual out-of-pocket maximum for midyear enrollments" section starting on page 2-18 for other information related to a midyear enrollment.

Your dependent will also be credited with an HRA balance under their Copay Plan with HRA COBRA continuation coverage that is equal to your available HRA balance as of the end of business on the last day your dependent was covered under your Copay Plan with HRA coverage. For example:

- An employee covers their spouse as a dependent under the Copay Plan with HRA for the 2022 plan year. The employee and spouse divorce on August 10, 2022, and the former spouse's coverage ends effective August 31, 2022. If your HRA balance on August 31, 2022 was $1,600, and your former spouse elects COBRA continuation coverage under the Copay Plan with HRA, your former spouse's HRA under their Copay Plan with HRA COBRA coverage would be credited with a $1,600 balance.
- An employee covers their child as a dependent under the Copay Plan with HRA for the 2022 plan year. The child turns age 26 on May 15, 2022, and the child's coverage ends effective May 31, 2022. If your HRA balance on May 31, 2022 was $500, and your child elects COBRA continuation coverage under the Copay Plan with HRA, your child's HRA under their Copay Plan with HRA COBRA coverage would be credited with a $500 balance.

Lifetime benefit accruals transfer under COBRA

Lifetime benefits accruals for infertility and fertility services and treatment will transfer to the Copay Plan with HRA COBRA continuation coverage for any individual who elects (or is covered as a dependent under) COBRA continuation coverage.

Midyear changes in claims administrator if you move to a different state or plan service area

If you move to a different state and remain enrolled in the Copay Plan with HRA, you may have a different claims administrator. Please review the "Medical plans by location" table on page 2-5 to determine the claims administrator for your state. Your change in claims administrator will be effective the first day of the month following your move. After your claims administrator change, your prior claims administrator will:

- Continue to process any eligible medical claims incurred before the effective date of the change of claims administrator and filed within 12 months of the date of service.

Beginning with the effective date of the change in claims administrator, your new claims administrator will:

- Send you a new member ID card and information about the transition.
- Process any medical claims received that were incurred on or after the effective date of change in claims administrator.
- Coordinate annual deductibles, annual out-of-pocket maximums, and lifetime benefits accruals for infertility and fertility services and treatment with the prior claims administrator during the period that both claims administrators are processing claims.

  Other benefit limits will not be transferred and will start over under your new claims administrator. These limits include the number of acupuncture, chiropractic, extended skilled nursing, home health care, therapy, and short-term rehabilitation visits; and the number of days in a skilled nursing facility.

If you terminate employment and choose COBRA continuation coverage for the Copay Plan with HRA, any remaining HRA dollars from your coverage as an employee will be available under your COBRA continuation coverage.

Midyear changes in medical plan benefit option

If you move to a different state or plan service area

If you have a change in residential address during the year, depending on where you move, your previous medical plan benefit option may not be available to you (such as an HMO — Kaiser, an HDHP — Kaiser medical plan, Narrow Network Copay Plan, or the Narrow Network Plan with HSA). If you elect to enroll in the Copay Plan with HRA midyear as a result of your change in residential address, please refer to the "HRA dollars, annual deductible, and annual out-of-pocket maximum for midyear enrollments" section starting on page 2-18 for more information.

If you have a change in residential address during the year, depending on where you move, you may have a new medical plan option available to you. To see available plan options, see the "Medical plans by location" table on page 2-5. If you elect to enroll in a new plan available to you as a result of your change in residential address, please refer to the appropriate midyear enrollment section for more information.

If you have a special enrollment right or Qualified Event

If you enroll in the Copay Plan with HRA midyear as a result of a special enrollment right or an allowable Qualified Event, please refer to the "HRA dollars, annual deductible, and annual out-of-pocket maximum for midyear enrollments" section starting on page 2-18 for more information.

If you are enrolled in the Copay Plan with HRA and as a result of a special enrollment right or an allowable Qualified Event elect coverage under another medical benefit option, your coverage under the Copay Plan with HRA will end and any remaining HRA dollars will be forfeited. For more information, see the "Terminating coverage in the Copay Plan with HRA" starting on page 2-16.

When you retire

Any reference to the *Retiree Benefits Book* or the Wells Fargo & Company Retiree Plan ("Retiree Plan") is for informational purposes only and the provisions of that plan are not part of any official plan provision under the Health Plan.

When you retire, your Copay Plan with HRA coverage terminates at the end of the month in which you retire.

Refer to the *Retiree Benefits Book* on the HR Services & Support site for information about your enrollment options when you retire.

If you do not elect the HRA-Based Medical Plan coverage under the Retiree Plan, see the "Terminating coverage in the Copay Plan with HRA" starting on page 2-16.

If you elect the HRA-Based Medical Plan coverage under the Retiree Plan as a retiree, HealthEquity will:

- Retain your HRA dollars, if any, for 60 days after the date your coverage terminates under the Copay Plan with HRA to allow you to pay for eligible claims incurred prior to the termination of coverage under the Copay Plan with HRA. After your coverage terminates, you will no longer be able to use your HealthEquity Healthcare Card. The Pay Me Back and Pay My Provider methods of payment will still be available during this period. After the 60 days, any remaining HRA dollars will not be available to pay for claims incurred under the Copay Plan with HRA.
- Initiate the transfer of any remaining HRA dollars as soon as administratively feasible, but no earlier than 61 days after the date your coverage terminates under the Copay Plan with HRA to your HRA under the Retiree Plan. Refer to "Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare" in the *Retiree Benefits Book* for more information.

When you terminate employment, become ineligible for coverage, or drop coverage

Coverage ends as described in the "When coverage ends" section in "Chapter 1: Eligibility, Enrollment, and More." You may be eligible to elect COBRA continuation coverage during your initial COBRA enrollment period.

- For information on COBRA continuation coverage, see "Appendix E: Continuing Coverage Under COBRA."
- For more information on COBRA continuation coverage specific to the Copay Plan with HRA, see the "COBRA enrollment" starting on page 2-20.

For information regarding your HRA balance, see the "Terminating coverage in the Copay Plan with HRA" starting on page 2-16.

Copay Plan with Health Reimbursement Account (HRA): Annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the Copay Plan with HRA and are subject to the procedures, exclusions, and limitations in this chapter. **Refer to the "Prescription drug benefit" section starting on page 2-146 for information about how prescription drugs are covered.**

Annual deductible	**Your annual deductible responsibility** Excludes copays and coinsurance for services that are not subject to the deductible. Also excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area[2] coverage**
You	$1,000	$4,000	$1,000
You + spouse[1]	$1,600	$6,400	$1,600
You + children	$1,350	$5,400	$1,350
You + spouse[1] + children	$1,900	$7,600	$1,900

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. These amounts apply to individuals whose home ZIP code is designated to be outside of the claims administrator's network service area and to services received from in-network or out-of-network providers.

Annual out-of-pocket maximum	**Your annual out-of-pocket maximum responsibility** Includes deductible, copays, and coinsurance; excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area[2] coverage**
You	$3,500	$10,000	$3,500
You + spouse[1]	$5,600	$16,800	$5,600
You + children	$4,550	$14,400	$4,550
You + spouse[1] + children	$6,650	$19,200	$6,650

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. These amounts apply to individuals whose home ZIP code is designated to be outside of the claims administrator's network service area and to services received from in-network or out-of-network providers.

Health and wellness	**Your available health and wellness dollars** See the "Health and wellness activities" section starting on page 2-37 for more information.
You	Up to $800
Your covered spouse[1]	Up to $800

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

How the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, and Flex HDHP work

The Higher Use Plan with HSA, Lower Use Plan with HSA, and the Narrow Network Plan with HSA are high-deductible health plans that are compatible with a health savings account (HSA) and are available nationwide to regular and fixed term employees, except in the state of Hawaii. These plans may be referred to collectively as "with HSA" medical plans.

- The HSA that you set up separately is not part of the Health Plan or any other ERISA-covered benefit plan sponsored by Wells Fargo. For more information about health savings accounts, see "Appendix C: Health Savings Accounts."
- You and your covered spouse or domestic partner may earn health and wellness dollars to be deposited in your health savings account with Optum Bank by participating in certain health- and wellness-related activities. For more information on earning health and wellness dollars by participating in health and wellness activities, see the "Health and wellness activities" section starting on page 2-37.

The Flex HDHP is also a high-deductible health plan that is solely available to interns and flexible employees. If you are an intern or flexible employee and enroll in the Flex HDHP, Wells Fargo will not facilitate the opening of an HSA with Optum Bank for you and you will not be permitted to make HSA contributions through payroll deductions or receive any employer contributions to your HSA (including health and wellness dollars).

These medical plans cover eligible expenses for covered health services. (See the "Covered health services definition" section starting on page 2-50 and the "Eligible expenses (allowed amount) definition" section starting on page 2-50 for more information.) Below is additional information to help you understand how the plans work.

- You pay 100% of eligible expenses for covered health services until you satisfy the applicable annual deductible, except as otherwise noted in the "Services covered under the medical plans" cost-sharing tables that start on page 2-54 and for prescription drugs, see page 2-146 for information about what you will pay for prescription drugs.
- After you satisfy the applicable annual deductible:
  - For in-network services and Out of Area coverage, you will typically pay 20% coinsurance for your share of eligible expenses for most covered health services.
  - For out-of-network services, you will typically pay 50% coinsurance for your share of eligible expenses for most covered health services.
  - For prescription drugs, you will pay the applicable copay.

  Refer to the "Services covered under the medical plans" section starting on page 2-53 and the corresponding cost-sharing tables starting on page 2-54 for more specific information on in-network, out-of-network, and Out of Area coverage, copays, cost-sharing percentages, and other requirements for covered health services.

  Refer to the "Prescription drug benefit" section starting on page 2-146 for information about what you will pay for prescription drugs.
- For certain covered health services (and drugs on the preventive drug therapy list) not subject to the annual deductible, the applicable coinsurance or copay does not count toward the annual deductible, but it does count toward the annual out-of-pocket maximum.
- After you satisfy the applicable annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services (for example, if you have met the in-network annual out-of-pocket maximum, the plan will pay 100% of eligible covered expenses for covered health services from an in-network provider for the remainder of the year, but it would not pay 100% of eligible expenses for covered health services received from an out-of-network provider until the out-of-network annual out-of-pocket maximum has been met).
- Additional information about services received from in-network providers:
  - The in-network provider should request any required pre-service authorizations for you.

    However, it's your responsibility to ensure that the necessary pre-service authorizations have been received before services are provided. For more information, see the "Pre-service authorization requirements" section starting on page 2-45.
  - The in-network provider will file claims for you.
- You pay 100% for services and expenses not covered under the medical plan; however, you are not responsible for any charges an in-network provider must write off as a result of its contract with the claims administrator or claims administrator's associated networks.

  For more information on in-network providers, see the "Providers and provider networks" section starting on page 2-9.
- Additional information about services received from out-of-network providers:
  - If you are enrolled in the Narrow Network Plan with HSA, you **do not** have coverage for services received from an out-of-network provider, except for emergency medical services. For more information, see "Emergency care" starting on page 2-72.
  - You must contact the claims administrator to receive required pre-service authorization for certain services (see the "Pre-service authorization requirements" section starting on page 2-45) before receiving those services from an out-of-network provider.

- You may be required to pay the out-of-network provider and file claim forms for reimbursement (for more information, see the "Claims and appeals" section starting on page 2-141). If the out-of-network provider files claims for you, then you are responsible for ensuring the provider follows the plan's claims filing requirements, including filing a claim within 12 months from the date of service.
- You pay 100% of expenses above the considered eligible expenses. An out-of-network provider can bill you for all expenses the plan does not cover, including those above the eligible expense (or allowed amount) and you are responsible for payment to the out-of-network provider. The difference between the out-of-network provider's charges and the eligible expense (allowed amount) under the medical plan is not applied toward the annual deductible, coinsurance amounts, or annual out-of-pocket maximum and is your responsibility. This applies to all out-of-network services described in this chapter, including Out of Area coverage.
- You pay 100% for services and expenses not covered by the medical plan.

Annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments

If you enroll midyear in one of the "with HSA" medical plans you are required to meet the full year annual deductible and annual out-of-pocket maximum regardless of your effective date of coverage during the year. However, the amount of health and wellness dollars that you and your covered spouse or domestic partner can earn will be prorated. For example, if you enroll midyear in the Lower Use Plan with HSA, with coverage effective July 1 at the you-only level of coverage, for the remainder of this plan year at this level of coverage the following would apply:

- In-network annual deductible of $3,000
- In-network annual out-of-pocket maximum of $5,250
- Eligible to earn up to $400 in health and wellness dollars

If you enroll midyear in the Flex HDHP, you are required to meet the full year annual deductible and out-of pocket maximum regardless of your effective date of coverage during the year. For example, if you enroll midyear in the Flex HDHP, with coverage effective July 1 at the you-only level of coverage, for the remainder of this plan year at this level of coverage the following would apply:

- In-network annual deductible of $3,000
- In-network annual out-of-pocket maximum of $5,250

Expenses incurred in a previous plan year or before the effective date of medical coverage under the Health Plan do not count toward the annual deductible or annual out-of-pocket maximum. If you enroll in the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP medical plan option mid-year as the result of changing from another medical plan option under the Health Plan (without a gap in coverage), amounts applied to your deductible or out-of-pocket maximum for the current plan year under the previous medical plan option will transfer to the applicable plan with HSA or the Flex HDHP. If you are changing from a Kaiser medical plan option under the Health Plan to one of the other medical plan options, you must provide your (and if applicable, your dependent's) most recent current year's Kaiser explanation of benefits (EOB) statement to your new claims administrator in order for the current year's annual deductible and out-of-pocket maximum accumulations to transfer from Kaiser to the new medical plan. If you are changing from one of the other medical plan options, you do not need to provide your EOB statement; it will be updated automatically.

The information above applies to an employee's midyear enrollment in any one of the "with HSA" medical plans or the Flex HDHP. The information above also applies to a covered dependent of an employee who enrolls in any one of the "with HSA" medical plans or the Flex HDHP midyear as a COBRA-qualified beneficiary. The above information does not apply to certain rehired retirees (see the "Rehired retirees" section starting on page 2-25).

Rehired COBRA participants

This section applies to you if you are an employee who is rehired by Wells Fargo and you had COBRA medical coverage under the Health Plan ("Health Plan") immediately preceding your rehire date.

If you had continuous COBRA medical coverage and you enroll in the Higher Use Plan with HSA, Lower Use Plan with HSA, or the Narrow Network Plan with HSA as a rehired employee with no lapse in coverage, any health and wellness dollars earned under the Health Plan will be prorated. However, for all medical plan options, your annual deductible and annual out-of-pocket maximum are not prorated, regardless of the level of coverage elected.

For example, if, as a COBRA participant, you were enrolled in the you-only level of coverage in the Lower Use Plan with HSA under COBRA medical coverage and, as a rehire, you enroll midyear in the Lower Use Plan with HSA under the Health Plan with coverage effective July 1 at the you-only level of coverage for the remainder of this plan year at this level of coverage, the following would apply:

- In-network annual deductible of $3,000
- In-network annual out-of-pocket maximum of $5,250
- Eligible to earn up to $400 in health and wellness dollars

As a rehired employee who had continuous COBRA medical coverage and enrolled in one of the "with HSA" medical plan or the Flex HDHP benefit options during the rehire enrollment period, the following will be applied to your coverage as an employee under the Health Plan:

- Amounts previously applied to your current year's COBRA annual deductible and annual out-of-pocket maximum will apply to your "with HSA" or the Flex HDHP medical plan benefit option annual deductible and annual out-of-pocket maximum for the same plan year (for eligible expenses incurred by you or eligible dependents you covered under your COBRA medical coverage of the Health Plan and who enroll in one of the "with HSA" or the Flex HDHP medical plan benefit options of the Health Plan).

- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.

Rehired retirees

Any reference to the Wells Fargo & Company Retiree Plan ("Retiree Plan") is for informational purposes only and the provisions of that plan are not part of any official plan provision under the Health Plan.

This section applies to you if you are a retiree who is rehired by Wells Fargo, you had retiree medical coverage under the Retiree Plan immediately preceding your date of rehire, and you elect the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP under the Health Plan as a rehired employee.

Your medical plan coverage under the Health Plan is effective on your date of rehire. Any health and wellness dollars earned under the Higher Use Plan with HSA, the Lower Use Plan with HSA, or the Narrow Network Plan with HSA will be prorated. (Interns and flexible employees enrolled in the Flex HDHP are not eligible for health and wellness dollars). For all medical plan options, your annual deductible and annual out-of-pocket maximum are not prorated, regardless of the level of coverage elected.

For example, if, as a rehired retiree, you enroll midyear in the Lower Use Plan with HSA under the Health Plan with coverage effective July 1 at the you-only level of coverage, for the remainder of this plan year at this level of coverage the following would apply:

- In-network annual deductible of $3,000
- In-network annual out-of-pocket maximum of $5,250
- Eligible to earn up to $400 in health and wellness dollars

As a rehired retiree who had retiree medical coverage under the HSA-Based Medical Plan benefit option under the Retiree Plan immediately preceding your date of rehire and who elects the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP benefit option under the Health Plan as a rehired employee, the following will be applied to your coverage as an employee under the Health Plan:

- Amounts previously applied to your current year's retiree annual deductible and annual out-of-pocket maximum will apply to your new medical plan annual deductible and annual out-of-pocket maximum for the same plan year (for eligible expenses incurred by you or eligible dependents that you covered under the HSA-Based Medical Plan benefit option of the Retiree Plan and who remain covered under the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP benefit option of the Health Plan).
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.

If your claims administrator changes as a result of your enrollment in the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP under the Health Plan upon your rehire, the claims administrator for your coverage under the Health Plan will only process any eligible medical claims incurred after the effective date of the change and filed within 12 months of the date of service.

If your retiree medical coverage under the Retiree Plan was a benefit option other than the HSA-based medical plan, none of your previous expenses under the Retiree Plan will be credited toward the annual deductible or annual out-of-pocket maximum for the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP under the Health Plan.

Note: If your retiree medical coverage under the Wells Fargo & Company Retiree Plan (Retiree Plan) immediately preceding your date of rehire is the UnitedHealthcare Medicare Advantage plan or the Kaiser Senior Advantage plan, your coverage under the Medicare Advantage option will end prospectively at the end of the month of your date of hire or as soon as administratively feasible, in accordance with CMS guidelines. This means you may have coverage under both the Retiree Plan and the Wells Fargo & Company Health Plan (Health Plan) for a short period of time. During any overlap period where you have coverage under both plans, the Health Plan is the primary plan. This means health care providers and pharmacies should submit claims first to the Health Plan and second to the Retiree Plan.

If your retiree medical coverage under the Retiree Plan immediately preceding your date of rehire was the UnitedHealthcare Medicare Advantage plan or the Kaiser Senior Advantage plan, this means you are enrolled in Medicare Part A and Part B. Once you are enrolled in Medicare, you can no longer contribute to an HSA. Please consult your tax advisor for more information.

Annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear changes

If you experience a midyear Qualified Event (see the "Qualified Events" section in "Chapter 1: Eligibility, Enrollment, and More") or other status change during the plan year resulting in an allowable change to your level of coverage, the annual deductible and the annual out-of-pocket maximum will be adjusted to reflect the new level of coverage for the year. However, the annual deductible and annual out-of-pocket maximum amounts are not prorated; you are required to meet the full year annual deductible and annual out-of-pocket maximum regardless of your effective date of coverage during the year.

Expenses incurred in a previous plan year or before the effective date of medical coverage in the Health Plan do not count toward the annual deductible or the annual out-of-pocket maximum. Eligible expenses incurred by any individual who is no longer enrolled in your plan as a result of the Qualified Event will apply toward your adjusted annual deductible and adjusted annual out-of-pocket maximum for the remainder of the plan year. If you enroll in the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP medical plan option mid-year as the result of changing from another medical plan option under the Health Plan (without a gap in coverage), amounts applied to your deductible or out-of-pocket maximum for the current plan year under the previous medical plan option will transfer to the applicable plan with HSA or the

Flex HDHP. If you are changing from a Kaiser medical plan option under the Health Plan to one of these medical plan options, you must provide your (and if applicable, your dependent's) most recent current year's Kaiser explanation of benefits (EOB) statement to your new claims administrator in order for the current year's annual deductible and out-of-pocket maximum accumulations to transfer from Kaiser to the new medical plan option under the Health Plan. If you are changing from one of the other Health Plan medical plan options, you do not need to provide your EOB statement; it will be updated automatically.

For regular and fixed term employees, when your level of coverage under the Higher Use Plan with HSA, the Lower Use Plan with HSA, or the Narrow Network Plan with HSA is increased due to a Qualified Event, your unearned health and wellness dollars are also adjusted to your new level of coverage for that plan year but are not prorated. However, health and wellness dollars are prorated for a spouse or domestic partner who is added midyear based on their effective date of coverage. For example, if your spouse is added to coverage on July 1, they would only be eligible to earn up to $400 for completing all health and wellness activities during the plan year.

COBRA enrollment

If you are eligible for and elect COBRA continuation coverage for the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP during your initial COBRA enrollment period at the same level of coverage you had under the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP as an employee, eligible covered expenses previously applied to the current year's annual deductible and annual out-of-pocket maximum for you, under your employee coverage, will apply to your COBRA continuation coverage for the current plan year.

If you extend coverage under the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP through COBRA and you do not elect the same level of coverage you had previously, your annual deductible and annual out-of-pocket maximum may be adjusted as previously described for the remainder of the plan year.

If your dependent is no longer eligible for coverage under your Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, or the Flex HDHP and elects COBRA medical coverage (separate from you) during the year, any charges that were incurred by the dependent and applied toward the current plan year annual deductible and annual out-of-pocket maximum under your previous employee coverage will count toward the dependent's new individual adjusted annual deductible and annual out-of-pocket maximum for the same plan year under COBRA medical coverage of the Health Plan. Also see the "Annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments" starting on page 2-24 for other information related to a midyear enrollment.

Lifetime benefits accruals for infertility and fertility services and treatment will transfer to any of the "with HSA" or Flex HDHP medical plans under COBRA continuation coverage for any individual who has COBRA continuation coverage.

Midyear changes in claims administrator if you move to a different state or plan service area

If you move to a different state or plan service area and remain enrolled in the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP that you were enrolled in before the move, you may have a different claims administrator. Please review the "Medical plans by location" starting on page 2-5 to determine the claims administrator for your state. Your change in claims administrator will be effective on the first day of the month following your move.

If you change from a Kaiser medical plan option to the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP, you must provide your (and if applicable, your dependent's) most recent current year's Kaiser explanation of benefits (EOB) statement to your new claims administrator in order for the current year's annual deductible and out-of-pocket maximum accumulations to transfer from Kaiser to the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network HSA Plan, or the Flex HDHP, as applicable. If you are changing from one of the other Health Plan medical plan options, you do not need to provide your EOB statement; it will be updated automatically.

After your claims administrator change, your prior claims administrator will continue to process any eligible medical claims incurred before the effective date of the change of claims administrator and filed within 12 months of the date of service.

Beginning with the effective date of the change in claims administrator, your new claims administrator will:

- Send you a new member ID card.
- Process any medical claims received that were incurred on or after the effective date of the change in claims administrator.
- Coordinate annual deductibles, annual out-of-pocket maximums, and lifetime benefits accruals for infertility and fertility services and treatment with the prior claims administrator during the period both claims administrators are processing claims.

  Other benefit limits will not be transferred and will start over under your new claims administrator. These limits include the number of acupuncture, chiropractic, extended skilled nursing, home health care, therapy, and short-term rehabilitation visits; and the number of days in a skilled nursing facility.

Midyear changes in medical plan benefit option

If you move to a different state or plan service area

If you have a change in residential address during the year, depending on where you move, your previous medical plan benefit option may not be available to you (such as an HMO — Kaiser or HDHP — Kaiser medical plan, the Narrow Network Copay Plan, or the Narrow Network Plan with HSA). If you elect to enroll in the Higher Use Plan with HSA or Lower Use Plan with HSA, or the Flex HDHP midyear as a result of your change in residential address, please refer to the "Annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments" starting on page 2-24 for more information. If you have a change in residential address during the year, depending on where you move, you may have a new medical plan option available to you. To see available plan options, see the "Medical plans by location" table on page 2-5. If you elect to enroll in one of the new plans available to you as a result of your change in residential address, please refer to the appropriate mid-year enrollment section for more information.

If you have a special enrollment right or a Qualified Event

If you enroll in one of the "with HSA" medical plans or Flex HDHP midyear as a result of a special enrollment right or an eligible Qualified Event, please refer to the "Annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments" starting on page 2-24 for more information.

As a regular or fixed term employee, if you are enrolled in the Higher Use Plan with HSA, the Lower Use Plan with HSA, or the Narrow Network Plan with HSA, and, as a result of a special enrollment right or an eligible Qualified Event, elect coverage under another medical benefit option such as the Copay Plan with HRA, Narrow Network Copay Plan, or one of the Kaiser medical plans, your coverage under the Higher Use Plan with HSA, Lower Use Plan with HSA, or the Narrow Network Plan with HSA will end. The claims administrator will continue to process any eligible medical claims incurred before the termination of coverage and filed within the required claims filing time period.

When you retire

Any reference to the *Retiree Benefits Book* or the Wells Fargo & Company Retiree Plan ("Retiree Plan") is for informational purposes only and the provisions of that plan are not part of any official plan provision under the Health Plan.

When you retire, your Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, or Flex HDHP coverage under the Health Plan terminates at the end of the month in which you retire.

Refer to the the *Retiree Benefits Book* on the HR Services & Support site for information about your enrollment options when you retire.

If you do not elect the HSA-Based Medical Plan coverage under the Retiree Plan, the claims administrator will continue to process any eligible medical claims incurred before the termination of coverage and filed within 12 months of the date of service.

When you terminate employment, become ineligible for coverage, or drop coverage

Coverage ends as described in the "When coverage ends" section in "Chapter 1: Eligibility, Enrollment, and More." You may be eligible to elect COBRA continuation coverage during your initial COBRA enrollment period.

- For more information on COBRA continuation coverage, see "Appendix E: Continuing Coverage Under COBRA."
- For more information on COBRA continuation coverage specific to the Higher Use Plan with HSA, the Lower Use Plan with HSA, or the Narrow Network Plan with HSA, or the Flex HDHP, see the "COBRA enrollment" starting on page 2-26.

If you do not elect COBRA continuation coverage for the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Flex HDHP, as applicable, the claims administrator will continue to process any eligible medical claims incurred before the termination of coverage and filed within 12 months of the date of service.

If you elect another medical benefit option at any time or otherwise elect to drop coverage under one of the "with HSA" medical plans or the Flex HDHP, your coverage under the applicable medical plan will end; however, the claims administrator will continue to process any eligible medical claims incurred prior to the termination of coverage and filed within the required claims filing time period.

Higher Use Plan with Health Savings Account (HSA): Annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the Higher Use Plan with HSA and are subject to the procedures, exclusions, and limitations in this chapter. **Refer to the "Prescription drug benefit" section starting on page 2-146 for information about how prescription drugs are covered.**

Annual deductible	**Your annual deductible responsibility** Excludes copays and coinsurance for services that are not subject to the deductible. Also excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area[2] coverage**
You	$2,000	$4,000	$2,000
You + spouse[1]	$3,200	$6,400	$3,200
You + children	$2,800	$5,400	$2,800
You + spouse[1] + children	$3,800	$7,600	$3,800

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. These amounts apply to individuals whose home ZIP code is designated to be outside of the claims administrator's network service area and to services received from in-network or out-of-network providers.

Annual out-of-pocket maximum	**Your annual out-of-pocket maximum responsibility** Includes your deductible, copays, and coinsurance; excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area[2] coverage**
You	$3,500	$6,000	$3,500
You + spouse[1]	$5,600	$9,600	$5,600
You + children	$4,550	$7,800	$4,550
You + spouse[1] + children	$6,650	$11,400	$6,650

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. These amounts apply to individuals whose home ZIP code is designated to be outside of the claims administrator's network service area and to services received from in-network or out-of-network providers.

Health and wellness	**Your available health and wellness dollars** See the "Health and wellness activities" section starting on page 2-37 for more information.
You	Up to $800
Your covered spouse[1]	Up to $800

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

Lower Use Plan with Health Savings Account (HSA): Annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the Lower Use Plan with HSA and are subject to the procedures, exclusions, and limitations in this chapter. **Refer to the "Prescription drug benefit" section starting on page 2-146 for information about how prescription drugs are covered.**

Annual deductible	**Your annual deductible responsibility** Excludes copays and coinsurance for services that are not subject to the deductible. Also excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area[2] coverage**
You	$3,000	$6,000	$3,000
You + spouse[1]	$4,800	$9,600	$4,800
You + children	$3,900	$7,800	$3,900
You + spouse[1] + children	$5,700	$11,400	$5,700

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. These amounts apply to individuals whose home ZIP code is designated to be outside of the claims administrator's network service area and to services received from in-network or out-of-network providers.

Annual out-of-pocket maximum	**Your annual out-of-pocket maximum responsibility** Includes your deductible, copays, and coinsurance; excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area[2] coverage**
You	$5,250	$10,500	$5,250
You + spouse[1]	$8,400	$16,800	$8,400
You + children	$6,825	$13,650	$6,825
You + spouse[1] + children	$9,975[3]	$19,950	$9,975[3]

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. These amounts apply to individuals whose home ZIP code is designated to be outside of the claims administrator's network service area and to services received from in-network or out-of-network providers.

3. No one individual will need to pay more than $8,700 in eligible medical and prescription drug expenses for the annual out-of-pocket maximum.

Health and wellness	**Your available health and wellness dollars** See the "Health and wellness activities" section starting on page 2-37 for more information.
You	Up to $800
Your covered spouse[1]	Up to $800

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

Narrow Network Plan with Health Savings Account (HSA): Annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the Narrow Network Plan with HSA and are subject to the procedures, exclusions, and limitations in this chapter. Covered services are described beginning on page 2-54. **Refer to the "Prescription drug benefit" section starting on page 2-146 for information about how prescription drugs are covered.** This plan is only available in certain locations (see the "Medical plans by location" table on page 2-5 for more information).

Annual deductible	**Your annual deductible responsibility** Excludes copays and coinsurance for services that are not subject to the deductible. Also excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area coverage**
You	$1,500	No coverage[2]	No coverage
You + spouse[1]	$3,000	No coverage[2]	No coverage
You + children	$2,800	No coverage[2]	No coverage
You + spouse[1] + children	$3,300	No coverage[2]	No coverage

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. Emergency care services are covered when received from out-of-network providers (see "Emergency care" on page 2-72 for more information).

Annual out-of-pocket maximum	**Your annual out-of-pocket maximum responsibility** Includes your deductible, copays, and coinsurance; excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area coverage**
You	$2,500	No coverage	No coverage
You + spouse*	$4,100	No coverage	No coverage
You + children	$3,500	No coverage	No coverage
You + spouse* + children	$5,000	No coverage	No coverage

* For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

Health and wellness	**Your available health and wellness dollars** See the "Health and wellness activities" section starting on page 2-37 for more information.
You	Up to $800
Your covered spouse*	Up to $800

* For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

Flexible High Deductible Health Plan (Flex HDHP): Annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the Flex HDHP Plan and are subject to the procedures, exclusions, and limitations in this chapter. **Refer to the "Prescription drug benefit" section starting on page 2-146 for information about how prescription drugs are covered.**

Annual deductible	**Your annual deductible responsibility** Excludes copays and coinsurance for services that are not subject to the deductible. Also excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area[2] coverage**
You	$3,000	$6,000	$3,000
You + spouse[1]	$4,800	$9,600	$4,800
You + children	$3,900	$7,800	$3,900
You + spouse[1] + children	$5,700	$11,400	$5,700

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. These amounts apply to individuals whose home ZIP code is designated to be outside of the claims administrator's network service area and to services received from in-network or out-of-network providers.

Annual out-of-pocket maximum	**Your annual out-of-pocket maximum responsibility** Includes your deductible, copays, and coinsurance; excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area[2] coverage**
You	$5,250	$10,500	$5,250
You + spouse[1]	$8,400	$16,800	$8,400
You + children	$6,825	$13,650	$6,825
You + spouse[1] + children	$9,975[3]	$19,950	$9,975[3]

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. These amounts apply to individuals whose home ZIP code is designated to be outside of the claims administrator's network service area and to services received from in-network or out-of-network providers.

3. No one individual will need to pay more than $8,700 in eligible medical and prescription drug expenses for the annual out-of-pocket maximum.

How the Narrow Network Copay Plan works

This medical plan is only available in certain locations. Refer to the "Medical plans by location" table on page 2-5 for more information.

The medical plan covers eligible expenses for covered health services. See the "Covered health services definition" section starting on page 2-50 and the "Eligible expenses (allowed amount) definition" section starting on page 2-50 for more information.

To receive benefits, you must use the claims administrator's network of providers. If you do not use the claims administrator's network of providers, services are not covered except in emergency situations.

When you receive services from in-network providers under the Narrow Network Copay Plan:

- You pay a copay for certain services (prescription drugs, office visits, convenience care in a retail setting, telemedicine, and urgent care). You do not need to meet the annual deductible before the copay applies. Refer to the "Services covered under the medical plans" section starting on page 2-53 and the corresponding cost-sharing tables starting on page 2-54 for more specific information on when copays apply to medical services. Refer to the "Prescription drug benefit" section starting on page 2-146 for information about what you will pay for prescription drugs.
- You pay 100% of eligible expenses for other covered health services until you satisfy the annual deductible except as otherwise noted in the "Services covered under the medical plans" cost-sharing tables that start on page 2-54 and for prescription drugs, (see page 2-146 for information about what you will pay for prescription drugs).
- After you satisfy the annual deductible, you will typically pay 20% coinsurance for your share of eligible expenses for covered health services (except for prescription drugs [see the "Prescription drug benefit" section starting on page 2-146 for information about what you will pay for prescription drugs]).
- For certain covered health services not subject to the annual deductible, the applicable copay or coinsurance does not count toward the annual deductible, but it does count toward the annual out-of-pocket maximum.
- After you satisfy your annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services for which coinsurance or copays would apply. The Plan would not, however, pay 100% of eligible expenses for covered emergency health services received from an out-of-network provider.
- The in-network provider should request any required pre-service authorizations for you. However, it's your responsibility to ensure that the necessary pre-service authorizations have been received before services are provided. For more information, see the "Pre-service authorization requirements" section starting on page 2-45.
- The in-network provider will file claims for you.
- You pay 100% for services and expenses not covered by the medical plan; however, you are generally not responsible for any charges an in-network provider must write off as a result of its contract with the claims administrator or the claims administrator's associated networks.

For more information on in-network providers, see the "Providers and provider networks" section starting on page 2-9.

No coverage for services received from an out-of-network provider

You do not have coverage for services received from out-of-network providers except for emergency medical services. For more information, see "Emergency care" on page 2-72.

If you receive emergency medical services from an out-of-network provider, the in-network annual deductible, coinsurance, and out-of-pocket maximums apply. The following also apply:

- You must contact the claims administrator to receive required pre-service authorizations for certain services (see the "Pre-service authorization requirements" section starting on page 2-45) before receiving those services from an out-of-network provider.
- You may be required to pay the out-of-network provider and file claims for reimbursement. (See the "Claims and appeals" section starting on page 2-141 for more information.) If the out-of-network provider files claims for you, you are responsible for ensuring the provider follows the plan's claims filing requirements, including filing a claim within 12 months from date of service.
- You pay 100% for expenses above those considered eligible expenses by the plan. An out-of-network provider can bill you for all expenses the plan does not cover, including those above the eligible expense (or allowed amount), and you are responsible for payment to the out-of-network provider. The difference between the out-of-network provider's billed charges and the eligible expense (allowed amount) is not applied toward the annual deductible, coinsurance amounts, or annual out-of-pocket maximum and is your responsibility. This applies to all out-of-network services described in this SPD chapter, including Out of Area coverage.
- You pay 100% for services and expenses not covered by the medical plan.

Note: If your retiree medical coverage under the Wells Fargo & Company Retiree Plan (Retiree Plan) immediately preceding your date of rehire is the UnitedHealthcare Medicare Advantage plan or the Kaiser Senior Advantage plan, your coverage under the Medicare Advantage option will end prospectively at the end of the month of your date of hire or as soon as administratively feasible, in accordance with CMS guidelines. This means you may have coverage under both the Retiree Plan and the Wells Fargo & Company Health Plan

(Health Plan) for a short period of time. During any overlap period where you have coverage under both plans, the Health Plan is the primary plan. This means health care providers and pharmacies should submit claims first to the Health Plan and second to the Retiree Plan.

Annual deductible and annual out-of-pocket maximum for midyear enrollments

If you enroll midyear in the Narrow Network Copay Plan, you are required to meet the full year annual deductible and annual out-of-pocket maximum regardless of your effective date of coverage during the year. For example, if you enroll midyear with coverage effective July 1 at the you-only level of coverage, for the remainder of this plan year at this level of coverage the following would apply:

- Your annual deductible would be $500.
- Your annual out-of-pocket maximum would be $3,000.

Expenses incurred in a previous plan year or before the effective date of medical coverage under the Health Plan do not count toward the annual deductible or annual out-of-pocket maximum. If you enroll in the Narrow Network Copay Plan medical plan option mid-year as the result of changing from another medical plan option under the Health Plan (without a gap in coverage), amounts applied to your deductible or out-of-pocket maximum for the current plan year under the previous medical plan option will transfer to the Narrow Network Copay Plan. If you are changing from a Kaiser medical plan option under the Health Plan to the Narrow Network Copay Plan, you must provide your (and if applicable, your dependent's) most recent current year's Kaiser explanation of benefits (EOB) statement to your new claims administrator in order for the current year's annual deductible and out-of-pocket maximum accumulations to transfer from Kaiser to the Narrow Network Copay Plan. If you are changing from one of the other Health Plan medical plan options, you do not need to provide your EOB statement; it will be updated automatically.

The information above applies to an employee's midyear enrollment in the Narrow Network Copay Plan. The above information also applies to a covered dependent of an employee who enrolls in the Narrow Network Copay Plan midyear as a COBRA-qualified beneficiary. The information above does not apply to certain rehired retirees (see the "Rehired retirees" section starting on this page).

Rehired COBRA participants

This section applies to you if you are an employee who is rehired by Wells Fargo & Company and you had COBRA medical coverage under the Health Plan immediately preceding your rehire date.

If you had continuous COBRA medical coverage and you enroll in the Narrow Network Copay Plan as a rehired employee with no lapse in coverage, your annual deductible and annual out-of-pocket maximum are not prorated regardless of the level of coverage elected. For example, if, as a COBRA participant, you were enrolled in the you-only level of coverage in the Narrow Network Copay Plan under COBRA continuation coverage and, as a rehire, you enroll midyear in the Narrow Network Copay Plan with coverage effective July 1 at the you-only level of coverage, for the remainder of this plan year at this level of coverage, the following would apply:

- In-network annual deductible of $500
- In-network annual out-of-pocket maximum of $3,000

As a rehired employee who had continuous COBRA medical coverage and enrolled in the Narrow Network Copay Plan during a rehire enrollment period, the following will be applied to your Narrow Network Copay Plan coverage as an employee under the Health Plan:

- Amounts previously applied to your current year's COBRA annual deductible and annual out-of-pocket maximum will apply to your new Narrow Network Copay Plan annual deductible and annual out-of-pocket maximum for the same plan year (for eligible expenses incurred by you or eligible dependents that you covered under your COBRA medical coverage under the Health Plan and who remain covered under the Narrow Network Copay Plan benefit option of the Health Plan).
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.

Rehired retirees

Any reference to the Wells Fargo Retiree Plan ("Retiree Plan") is for informational purposes only and the provisions of that plan are not part of any official plan provision under the Health Plan.

This section applies to you if you are a retiree who is rehired by Wells Fargo , who had retiree medical coverage under the Retiree Plan immediately preceding your date of rehire, and you elect the Narrow Network Copay Plan benefit option under the Health Plan as a rehired employee.

Your Narrow Network Copay Plan coverage under the Health Plan is effective on your date of rehire. Your annual deductible and annual out-of-pocket maximum are not prorated, regardless of the level of coverage elected. For example, if, as a rehired retiree, you enroll midyear in the Narrow Network Copay Plan under the Health Plan with coverage effective July 1 at the you-only level of coverage, for the remainder of this plan year at this level of coverage the following would apply:

- In-network annual deductible of $500
- In-network annual out-of-pocket maximum of $3,000

Your retiree medical coverage expenses under the Retiree Plan will not count toward the annual deductible or annual out-of-pocket maximum for the Narrow Network Copay Plan under the Health Plan.

Annual deductible and annual out-of-pocket maximum for midyear changes

If you experience a midyear Qualified Event (see the "Qualified Events" section in "Chapter 1: Eligibility, Enrollment, and More") or other status change during the plan year resulting in an allowable change to your level of coverage, the annual deductible and the annual out-of-pocket maximum will be adjusted to reflect the new level of coverage for the year. However, the annual deductible and annual out-of-pocket maximum amounts are not prorated; you are required to meet the full year annual deductible and annual out-of-pocket maximum regardless of your effective date of coverage.

Expenses incurred in a previous plan year or before the effective date of medical coverage in the Health Plan do not count toward the annual deductible or annual out-of-pocket maximum. Eligible expenses incurred by any individual who is no longer enrolled in your plan as a result of the Qualified Event will apply toward your adjusted annual deductible and adjusted annual out-of-pocket maximum for the remainder of the plan year. If you enroll in the Narrow Network Copay Plan medical plan option mid-year as the result of changing from another medical plan option under the Health Plan (without a gap in coverage), amounts applied to your deductible or out-of-pocket maximum for the current plan year under the previous medical plan option will transfer to the Narrow Network Copay Plan. If you are changing from a Kaiser medical plan option under the Health Plan to the Narrow Network Copay Plan, you must provide your (and if applicable, your dependent's) most recent current year's Kaiser explanation of benefits (EOB) statement to your new claims administrator in order for the current year's annual deductible and out-of-pocket maximum accumulations to transfer from Kaiser to the Narrow Network Copay Plan. If you are changing from one of the other Health Plan medical plan options, you do not need to provide your EOB statement; it will be updated automatically.

COBRA enrollment

If you are eligible for and elect COBRA continuation coverage for the Narrow Network Copay Plan during your initial COBRA enrollment period at the same level of coverage you had under the Narrow Network Copay Plan as an employee, eligible covered expenses previously applied to the current year's annual deductible and annual out-of-pocket maximum for you, under your employee Narrow Network Copay Plan coverage, will apply to your Narrow Network Copay Plan COBRA continuation coverage for the same plan year.

If you extend coverage under your Narrow Network Copay Plan through COBRA and you do not elect the same level of coverage you had previously, your annual deductible and annual out-of-pocket maximum may be adjusted as previously described for the remainder of the plan year.

If your dependent is no longer eligible for coverage under your Narrow Network Copay Plan coverage and elects COBRA medical coverage (separate from you) under the Health Plan during the year, any charges that were incurred by the dependent and applied toward the current year annual deductible and annual out-of-pocket maximum under your previous employee coverage will count toward the dependent's new individual adjusted annual deductible and annual out-of-pocket maximum for the same plan year under COBRA medical coverage of the Health Plan. Also see the "Annual deductible and annual out-of-pocket maximum for midyear enrollments" section starting on page 2-33 for other information related to a midyear enrollment.

Lifetime benefits accruals for infertility and fertility services and treatment will transfer to the Narrow Network Copay Plan COBRA continuation coverage for any individual who has COBRA continuation coverage.

Midyear changes in claims administrator if you move to a different state or plan service area

If you move to a different state or plan service area and remain enrolled in the Narrow Network Copay Plan that you were enrolled in before the move, you may have a different claims administrator. Please review the "Medical plans by location" starting on page 2-5 to determine the claims administrator for your state. Your change in claims administrator will be effective on the first day of the month following your move.

After your claims administrator change, your prior claims administrator will continue to process any eligible medical claims incurred before the effective date of the change of claims administrator and filed within 12 months of the date of service.

Beginning with the effective date of the change in claims administrator, your new claims administrator will:

- Send you a new member ID card.
- Process any medical claims received that were incurred on or after the effective date of the change in claims administrator.
- Coordinate annual deductibles, annual out-of-pocket maximums, and lifetime benefits accruals for infertility and fertility services and treatment with the prior claims administrator during the period both claims administrators are processing claims.

Other benefit limits will not be transferred and will start over under your new claims administrator. These limits include the number of acupuncture, chiropractic, extended skilled nursing, home health care, therapy, and short-term rehabilitation visits, and the number of days in a skilled nursing facility.

Midyear change in medical plan benefit option

If you move to a different state or plan service area

If you have a change in residential address during the year, your previous medical plan benefit option may not be available to you (such as an HMO — Kaiser or HDHP — Kaiser medical plan, Narrow Network Plan with HSA, or the Narrow Network Copay Plan), depending on where you move. If you elect to enroll in the Narrow Network Copay Plan midyear as a result of your change in residential address, please refer to the "Annual deductible and annual out-of-pocket maximum for midyear enrollments" section starting on page 2-33 for more information.

If you have a change in residential address during the year, depending on where you move, you may have a new medical plan option available to you. To see available plan options, see the "Medical plans by location" table on page 2-5. If you elect to enroll in one of the new plans available to you as a result of your change in residential address, please refer to the appropriate midyear enrollment section for more information.

If you have a special enrollment right or Qualified Event

If you enroll in the Narrow Network Copay Plan midyear as a result of a special enrollment right or an eligible Qualified Event, please refer to the "Annual deductible and annual out-of-pocket maximum for midyear enrollments" section starting on page 2-33 for more information.

When you retire

Any reference to the Wells Fargo Retiree Plan ("Retiree Plan") is for informational purposes only and the provisions of that plan are not part of any official plan provision under the Health Plan.

When you retire, your Narrow Network Copay Plan coverage under the Health Plan terminates at the end of the month in which you retire.

Refer to the the *Retiree Benefits Book* on the HR Services & Support site for information about your enrollment options when you retire.

The Narrow Network Copay Plan is not a benefit option under the Retiree Plan. The claims administrator will continue to process any eligible medical claims incurred before the termination of coverage and filed within 12 months of the date of service.

When you terminate employment, become ineligible for coverage, or drop coverage

Coverage ends as described in the "When coverage ends" section in "Chapter 1: Eligibility, Enrollment, and More." You may be eligible to elect COBRA continuation coverage during your initial COBRA enrollment period.

- For more information on COBRA continuation coverage, see "Appendix E: Continuing Coverage Under COBRA."
- For more information on COBRA continuation coverage specific to the Narrow Network Copay Plan, see the "COBRA enrollment" starting on page 2-34.

If you elect another medical benefit option at any time or otherwise elect to drop your Narrow Network Copay Plan coverage, your coverage under the Narrow Network Copay Plan will end; however, the claims administrator will continue to process any eligible medical claims incurred prior to the termination of coverage and filed within the claims filing period.

If your dependent is no longer eligible for coverage and elects COBRA continuation coverage under the Narrow Network Copay Plan, see the "Annual deductible and annual out-of-pocket maximum for midyear enrollments" section starting on page 2-33 for more information. If your dependents become eligible for their own individual coverage under COBRA, any charges that were incurred by them and applied toward the previous annual deductible under your coverage do not count toward the dependent's applicable annual deductible and annual out-of-pocket maximum as a result of their COBRA enrollment.

The Narrow Network Copay Plan: Annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the Narrow Network Copay Plan and are subject to the procedures, exclusions, and limitations in this chapter. Covered services are described beginning on page 2-54. **Refer to the "Prescription drug benefit" section starting on page 2-146 for information about how prescription drugs are covered.** This plan is only available in certain locations (see the "Medical plans by location" table on page 2-5 for more information).

Annual deductible	**Your annual deductible responsibility** Excludes copays and coinsurance for services that are not subject to the deductible. Also excludes expenses and services not covered by the plan.		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area coverage**
You	$500	No coverage[2]	No coverage
You + spouse[1]	$800	No coverage[2]	No coverage
You + children	$700	No coverage[2]	No coverage
You + spouse[1] + children	$1,000	No coverage[2]	No coverage

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

2. Emergency care services are covered when received from out-of-network providers (see "Emergency care" on page 2-72 for more information).

Annual out-of-pocket maximum	**Your annual out-of-pocket maximum responsibility** Includes your annual deductible, copays, and coinsurance; excludes expenses and services not covered by the plan		
Coverage	**In-network providers**	**Out-of-network providers**	**Out of Area coverage**
You	$3,000	No coverage	No coverage
You + spouse*	$4,800	No coverage	No coverage
You + children	$3,900	No coverage	No coverage
You + spouse* + children	$5,700	No coverage	No coverage

* For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

Health and wellness activities

The Wells Fargo health and well-being program is a voluntary wellness program available to all regular and fixed term employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you enroll in the Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or an HDHP — Kaiser medical plan, you and your covered spouse or domestic partner have an opportunity to earn health and wellness dollars to be deposited to your health savings account or allocated to your health reimbursement account, as applicable, when you complete certain health and wellness-related activities.

In order to participate in these health and wellness activities and earn health and wellness dollars, you and your covered spouse or domestic partner must be at least 18 years of age. (Covered dependent children are not eligible to participate in health and wellness activities.)

You and your covered spouse or domestic partner cannot earn health and wellness dollars for repeating the same activity or program during the same plan year unless otherwise specified.

Health and wellness dollars may be used for eligible medical expenses only after the health and wellness dollars have been deposited to your health savings account or allocated to your health reimbursement account, as applicable.

Optum is the administrator of all health and wellness activities. Participation in activites is faciliated through Rally. Listed on the following pages are the specific activities and the amount of health and wellness dollars that can be earned per activity. **You must complete health and wellness activities between January 1, 2022, and November 15, 2022, to earn health and wellness dollars for the 2022 plan year.**

Note: Health and wellness dollars are not available to participants of the Narrow Network Copay Plan, HMO — Kaiser medical plans, or POS Kaiser Added Choice — Hawaii or the Flex HDHP plan.

Activity Description	Action	Dollar Amount
Online Health Survey The online health survey can help you identify lifestyle risks, reinforce healthy habits, and learn about resources to improve your health.	Complete the health survey	$50
Biometric Screening A biometric screening will check your blood pressure, cholesterol, and other health indicators.	Complete a biometric screening	$300
Preventive Care Complete your annual physical and routine preventive screenings.	Complete recommended preventive care Men: • Annual physical • Colonoscopy, sigmoidoscopy, or Cologuard® Women: • Annual physical • Cervical screening • Mammogram • Colonoscopy, sigmoidoscopy, or Cologuard®	$150 each

Activity Description	Action	Dollar Amount
Second Medical Opinion (2nd.MD) Employees have access to a second medical opinion service, 2nd.MD, at no additional cost where you can ask medical experts questions through a video or phone consultation. **Note:** HDHP — Kaiser medical plan members do not have access to 2nd.MD	Register for an account with 2nd.MD	$100
Wellness Coaching Wellness Coaching is all about helping you get and stay healthy. Choose Wellness Coaching and work one-on-one with a coach by phone or live chat.	Complete three calls	$300
Online Wellness Coaching Wellness Coaching is all about helping you get and stay healthy. Choose Online Coaching to learn at your own pace.	Complete all lessons in an online program	$150
Maternity Support If you are pregnant, you can receive educational information and tips for a healthy pregnancy. **Note:** HDHP — Kaiser medical plan members will not earn health and wellness dollars for maternity support.	Complete three calls	$300
Condition Management The claims administrators provide responsive disease management programs that identify, assess, and support members with specific chronic conditions. **Note:** HDHP — Kaiser medical plan members will not earn health and wellness dollars for condition management.	Complete three calls	$300
Real Appeal Real Appeal is an online weight loss program available to eligible medical plan participants at no additional cost. See page 2-41 for eligibility details. **Note:** HDHP — Kaiser medical plan members do not have access to Real Appeal.	Complete nine sessions	$300
Livongo® Livongo is a program that helps make living with diabetes easier by providing you with an advanced meter, unlimited strips, remote coaching support, and more. **Note:** HDHP — Kaiser medical plan members do not have access to Livongo.	Enroll in Livongo and complete four blood-sugar checks for two consecutive months using the Livongo meter	$300
Quit For Life Quit for Life is an online tobacco cessation program that can help you quit tobacco for good. It is available to eligible medical plan participants at no additional cost. **Note:** HDHP - Kaiser medical plan members do not have access to Quit for Life.	Complete five interactions with a coach to complete the program	$300
Rally Missions Missions are online activities that help guide you in small steps toward better health and well-being.	Complete three missions	$150
Rally Challenges Participate in a variety of well-being challenges.	Complete the blue milestone circle	$50 each (up to four per year)
Financial Health Video Watch a short video to learn about resources that are available to help support your financial health and then complete an attestation.	Watch a video and complete the quiz	$100

The amounts stated in the tables on pages 2-37 and 2-38 reflect the maximum amount of health and wellness dollars available for deposit in your health savings account or allocated to your health reimbursement account, as applicable, upon completion of the specified health and wellness activities.

- Employees may earn a maximum of $800 health and wellness dollars per calendar year.
- Enrolled spouses or domestic partners may earn a maximum of $800 health and wellness dollars per calendar year.

These amounts will be prorated for midyear enrollments and may be prorated for midyear status changes that affect your level of coverage.

Benefit effective date occurs during:	Maximum health and wellness dollars
Quarter 1 (January – March)	$800
Quarter 2 (April – June)	$600
Quarter 3 (July – September)	$400
Quarter 4 (October and November*)	$200

* All health and wellness dollars must be earned by November 15, 2022.

In certain cases, these amounts may be reduced due to legal limitations imposed under applicable law or program administration provisions (even if you and your covered spouse or domestic partner complete the required health and wellness activities).

- For the earned health and wellness dollars to be allocated to your health reimbursement account, you must be a participant in the Copay Plan with HRA at the time the activity is completed.
- For the earned health and wellness dollars to be deposited into your health savings account:
  - You must be a participant in the Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, or an HDHP — Kaiser medical plan at the time the activity is completed.
  - You must have an open health savings account with Optum Bank for the plan year in which health and wellness dollars were earned and the health savings account must be open on the date the health and wellness dollars are to be deposited.
  - You must be in a position to receive additional health savings account contributions. In other words, your account cannot have an administrative hold on it and the contribution limit must not have been reached.

    If, at the time the dollars are to be deposited, your health savings account is not open or able to receive contributions, you may not receive the health and wellness dollars, even if you completed the activities.

If you do not have a health savings account open with Optum Bank (or your health savings account is not eligible to receive these health and wellness dollars as eligible contributions) on the date the health and wellness dollars are to be deposited, you will not receive these health and wellness dollars even if you otherwise completed the wellness activities.

You and your covered spouse or domestic partner cannot receive health and wellness dollars for repeating the activities or programs during this same plan year.

Who's eligible to earn health and wellness dollars?

To be eligible to earn health and wellness dollars, you must be enrolled in one of the following plans: the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, or an HDHP — Kaiser medical plan under the Health Plan. Only you and your covered spouse or domestic partner are eligible to complete the health and wellness activities and earn health and wellness dollars after your medical coverage effective date. In order to participate in health and wellness activities and earn health and wellness dollars, you and your covered spouse or domestic partner must be at least 18 years of age. Covered dependent children are not eligible to earn health and wellness dollars regardless of age.

You are also eligible to earn health and wellness dollars if you have elected COBRA coverage under one of these medical plans or are on an approved leave of absence. However, you cannot receive health and wellness dollars for completing the same activity or program during the same plan year. For example, if you earned health and wellness dollars during the plan year before your COBRA coverage election, you may not repeat the same activity and earn additional health and wellness dollars.

Dependent children, age 18 or older, who elect individual COBRA coverage will be eligible to earn prorated health and wellness dollars based on the effective date of individual COBRA coverage.

Health and wellness activities

The health and wellness activities you can choose from that allow you to earn health and wellness dollars are described below. You are not required to participate in health and wellness activities, as the wellness program is voluntary; however, only employees who complete the activities will receive health and wellness dollars.

You may receive a phone call from Optum, Rally, or your medical plan's claims administrator to invite you to participate in one of the programs mentioned below.

Rally will help you monitor completion of these activities and the health and wellness dollars you've earned. Access to Rally is provided through wellness.myoptumhealth.com, the Rally mobile app, the HR Services & Support site (accessible from work), or teamworks.wellsfargo.com (accessible from home). The mobile app should be used on personal devices only and should not be used on Wells Fargo-owned devices.

Health survey

The health survey is an online tool that takes about 15 minutes to complete and can help you understand your health status today. You are also encouraged to share your results or concerns with your own doctor.

The health survey can be completed on the Rally website or mobile app. The mobile app should be used on personal devices only and should not be used on Wells Fargo-owned devices.

If you do not have online access to a computer, a paper copy of the health survey may be requested by calling Rally Support at 1-877-543-4294.

Biometric screenings

Biometric screenings can help you determine if you may be at risk for certain diseases and conditions. The biometric screenings will measure your blood pressure and body mass index (BMI), and through a simple blood draw, determine your cholesterol and blood glucose levels. You are encouraged to share your results or concerns with your own doctor.

Biometric screenings can be completed in one of five ways:

1. Participate in one of the on-site screening events (if available) provided by Optum, held at select larger work sites (on-site screening events are for employees only).
2. Receive your screening from your personal physician.
3. Visit a CVS MinuteClinic location, if available, and receive your screening. (HDHP — Kaiser members do not have access to MinuteClinic locations and must obtain their screening through their personal physician or at an on-site screening event.)
4. Make an appointment to receive your screening at a Quest Diagnostics Patient Service Center. A Physician Results Form is not needed at these locations.
5. Complete your biometric screening in the comfort of your home by using a self-collection kit. You will need to collect a small blood specimen via a self-administer finger stick using the provided materials.

   Request a self-collection kit on to the Rally website — wellness.myoptumhealth.com. Self-collection kits must be ordered by November 1, 2022, and post-marked for return by November 15, 2022.

In order to earn 2022 health and wellness dollars for a biometric screening received from your personal physician or at a CVS MinuteClinic, you must receive your biometric screening between January 1, 2022, and November 15, 2022, while covered under a Wells Fargo account-based medical plan.

Note: While it is intended that a biometric screening you receive from your personal physician will be an eligible preventive care service under the Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, and an HDHP — Kaiser medical plan, whether your biometric screening is in fact treated as an eligible preventive care service will depend solely on how your physician codes the claim. Once the claim is filed, the claim will be processed based on how your provider coded the claim. For more information on eligible preventive care services, see the "Preventive care services (eligible preventive care services)" section starting on page 2-114.

For screenings received from your physician, the medical provider will need to complete a Physician Results form and you or your physician will need to submit the completed and signed form to Optum/Quest Diagnostics.

For screenings received at a CVS MinuteClinic, you will need to submit the completed and signed Physician Results form to Optum/Quest Diagnostics. The CVS MinuteClinic provider is not able to submit the form to Optum on your behalf. There should be no cost to you for a biometric screening received at a CVS MinuteClinic.

For screenings received at a Quest Diagnostics Patient Service Center, no form is needed.

You can obtain a copy of the Physician Results form on the Rally website by logging into your Rally account at wellness.myoptumhealth.com. The completed and signed Physician Results form must be submitted to Optum/Quest Diagnostics no later than November 15, 2022. Submit your completed and signed Physician Results form directly to Optum/Quest Diagnostics. You have the option to upload the form on the Optum/Quest Diagnostics website or fax it to 1-844-560-5221.

It is your responsibility to ensure that your provider completes the Physician Results form correctly and that the Physician Results form is submitted to Optum/Quest Diagnostics before the deadline. Forms with a postmark or a fax received date after November 15, 2022, will not be accepted.

Note: Biometric screenings completed between November 16, 2021, and December 31, 2021, will not be eligible for 2022 health and wellness dollars.

Preventive Care

Complete one or more of the following preventive exams/screenings:

- Annual physical
- Mammogram
- Colonoscopy, sigmoidoscopy, and Cologuard®
- Cervical screening

For a service to be considered an eligible preventive care service, it must be a preventive care service recommended by one of several federal government or independent agencies responsible for the development and monitoring of various U.S. preventive care services.

Wellness coaching

Coaching can help you identify health risks, set goals, and develop personalized strategies that will empower you to make positive lifestyle changes and improve your health and well-being.

To earn health and wellness dollars for participating in coaching, you must complete three sessions with your coach (includes telephonic or chat sessions).

More information, including available topics, can be found on the Rally website or mobile app. The mobile app should be used on personal devices only and should not be used on Wells Fargo-owned devices.

Online wellness coaching

Online wellness coaching offers tools to help you make positive lifestyle changes and improve your health and well-being.

To earn health and wellness dollars for participating in online coaching, you must complete all modules in a digital program.

Maternity support

If you are pregnant, you can receive educational information and tips for a healthy pregnancy. Pregnant employees or enrolled spouses and domestic partners may earn health and wellness dollars by completing three calls in the maternity support program.* Contact your claims administrator as early in your pregnancy as possible to participate in the program.

* HDHP — Kaiser and Narrow Network Copay Plan members cannot earn health and wellness dollars for the maternity support program.

Condition management

The claims administrators provide responsive disease management programs that identify, assess, and support members with specific chronic conditions. Chronic condition support is available for:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Diabetes
- Heart failure

Employees and enrolled spouses and domestic partners who have one of the above mentioned conditions may earn health and wellness dollars by completing three calls in the condition management program.*

* HDHP — Kaiser members cannot earn health and wellness dollars for condition management programs.

Real Appeal

Real Appeal* is a digital weight loss program that can help you lose weight and may help reduce your risk of developing certain diseases like diabetes and cardiovascular disease. Real Appeal is available to employees, spouses, domestic partners, and adult dependents (ages 18 – 26) with a Body Mass Index (BMI) of 23 or greater. To earn the applicable health and wellness dollars for participating in Real Appeal, you must complete nine sessions with your coach.

To enroll or if you would like additional information, visit realappeal.com or call Real Appeal at 1-844-924-7325. Adult dependents should call Rally Support at **1-877-543-4294** to enroll.

* Real Appeal is not available to individuals enrolled in the Kaiser medical plans.

Livongo

Livongo* is a program that provides participants living with diabetes with an advanced meter, unlimited strips, remote coaching support, and more. The program is offered at no cost to participants and covered family members with diabetes.

To earn health and wellness dollars for participating in Livongo, enroll in the program and complete four blood-sugar checks each month for two consecutive months using the Livongo meter.

* Kaiser members are not eligible for this program.

Quit for Life

Quit for Life* is designed to help you quit tobacco for good. You can work with a coach online or on the phone and interact with the Quit for Life app to keep you on track towards your quit date.

Quit for Life can be found on the Rally website or mobile app. The mobile app should be used on personal devices only and should not be used on Wells Fargo-owned devices.

To earn health and wellness dollars for participating in Quit for Life, enroll in the program and complete five interactions with a coach.

* Kaiser members are not eligible for this program.

Rally Missions

Missions are designed to help you improve your daily health habits and behaviors while educating you about certain health topics. You must complete three separate Missions to earn the applicable health and wellness dollars. Missions take a minimum of four weeks to complete.

Missions can be found on the Rally website or mobile app. The mobile app should be used on personal devices only and should not be used on Wells Fargo-owned devices.

Rally Challenges

Challenges are great way to push yourself and engage in healthy, competitive activities with others in the Rally community. Complete up to four challenges to earn the applicable health and wellness dollars ($50 for each completed challenge). Private or user-created challenges are not eligible for health and wellness dollars.

Rally Challenges can be found on the Rally website or mobile app. The mobile app should be used on personal devices only and should not be used on Wells Fargo-owned devices.

Second medical opinion (2nd.MD)

Second medical opinion (2nd.MD)* is a service that provides access to personalized second opinions, by video or phone, at no additional charge. Access is provided through convenient consultations from leading medical experts.

Earn health and wellness dollars by registering for an account with 2nd.MD. Registrations completed after January 1, 2020, are eligible for the incentive.

*It is educational in nature and does not diagnose, treat, or prescribe treatment of medical conditions.

Financial Health Video

Watch a short video to learn about resources that are available to help support your financial health and then complete an attestation to earn health and wellness dollars.

Health and wellness dollar disputes

If it has been more than 30 days since you have completed or attested to completing an activity and health and wellness dollars have not been allocated to your health reimbursement account (HRA) or deposited into your health savings account (HSA) contact the Optum Rally Support team at 1-877-543-4294 to open a case for investigation (an inquiry).

For 2021 health and wellness dollars, you must open your case for investigation with Rally via a phone call or through the Rally portal no later than June 30, 2022. Requests for 2021 health and wellness dollars received later than June 30, 2022, will be denied.

The Optum Rally Support team will issue a written response to your case within 30 days of the receipt of your request. If your request is approved, based on investigation of the case, applicable health and wellness dollars will be allocated to your HRA or deposited into your HSA as applicable.

If you have any questions, call the Optum Rally Support Team at 1-877-543-4294.

Note: You cannot appeal the availability of health and wellness dollars with your medical claims administrator.

Requests for accommodations

The health and wellness activities under the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, and an HDHP — Kaiser medical plan are participatory wellness programs and do not require you to achieve particular health outcomes. There may be situations where you are unable to complete an activity to earn health and wellness dollars. For example, if you have a serious medical condition, your physician may not agree to provide you with a biometric screening. If you (or your covered spouse or domestic partner) are unable to complete an activity to earn health and wellness dollars, you may fax a request for accommodations to Optum at 1-888-608-2010. You must complete the Health Provider Screening Accommodation form that can be found on the HR Services & Support site. For 2022 health and wellness dollars, the Health Provider Screening Accommodation form must be submitted no later than November 15, 2022.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Wells Fargo may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who may receive your personally identifiable health information are you and your medical plan's claims administrator, and depending on the program you may participate in, the following individuals may have access to your personally identifiable health information: health coaches, health advocates, or nurses in order to provide you with services under the wellness program. Optum, Rally, and their respective partners or affiliates may also have access to your personally identifiable health information for administrative purposes.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

Other programs, tools, and resources

Optum, Rally Health, and the claims administrators for the Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, and the Narrow Network Copay Plan offer additional programs, tools, and resources to help employees and covered dependents better manage their health and make healthier lifestyle choices.

These resources are voluntary, confidential, and available at no additional cost to employees and covered dependents. Optum provides telephonic wellness coaching, and web-based tools and resources, including online wellness education programs, through their Rally Health Portal. Each of these is described in more detail below.

The medical claims administrators, Express Scripts, and Optum work together as part of an integrated health management program to provide resources to support your health. The programs and services offered may include education about a condition or individual support from a nurse. You may also receive an outreach call to enroll in a telephonic wellness

coaching program or other programs offered through your claims administrator. Participation in these programs is voluntary. These services are offered at no cost to participants and are described below.

24-hour NurseLine

Nurses are available 24 hours a day, 365 days a year to deliver symptom decision support, evidence-based health information and education, and medication information.

- **UnitedHealthcare:** Call NurseLine at 1-800-842-9722.
- **Anthem BCBS:** Call NurseLine at 1-866-220-4849.
- **Aetna:** Call NurseLine at 1-800-556-1555.

Autism Spectrum Disorder (ASD) Support

ASD Support provides a single point of contact to help members connect with available programs and resources, and works closely with our other clinical and customer services teams to ensure families impacted by autism have access to the right care and information. Autism-focused, licensed behavioral health clinicians provide support and act as consultants to the interdisciplinary team surrounding the member, helping them navigate and address the unique challenges facing families with an autistic child. The result is enhancement of the member's overall experience, effective use of benefits, and access to coordinated and appropriate care.

Behavioral Health Resources

The medical plans offer behavioral health case managers support. The case managers are licensed mental health professionals whose goals are to help you take control of your health care and improve your quality of life. They are there to help provide support for you and your family.

Your case manager will work with you to:

- Help you and your family understand your condition
- Develop a personalized plan to help you reach your behavioral health goals
- Identify and help you overcome hurdles that may be keeping you from reaching your goals
- Connect with helpful community and online resources
- Review and coordinate services you get from local and community providers
- Help ensure you're getting all the benefits available to you under your health plan
- Become your own advocate by working with a dedicated and specialized team of resources to meet your needs

On your first call together, your case manager will ask you questions to better understand what you're dealing with, where you are in your treatment, and what you hope to achieve. After that call, the case manager will begin making a plan to help you meet your goals. They will stay in touch with you as you work toward those goals.

If you'd like to learn more about our Behavioral Health Case Management programs contact your claims administrator and ask to speak to a Behavioral Health Case Manager.

Complex case management

Designed for participants with certain chronic or complex conditions, these programs address such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

Cancer support

Cancer management programs provide guidance and help ensure coordination of resources for your treatment. Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

Health education materials

Each of the claims administrators also provides tools and educational materials to help you stay healthy. These services can be accessed by visiting the claims administrator's website or by calling the member services number on your card.

2nd.MD — second medical opinion

Second medical opinion, available through 2nd.MD, is a service that provides access to personalized second opinions, by video or phone, at no additional charge. Access is provided through convenient consultations from leading medical experts within three to five days through 2nd.MD. This additional medical information may help you make more informed decisions about your care.*

*It is educational in nature and does not diagnose, treat, or prescribe treatment of medical conditions.

Medical specialty drugs administered by a medical provider (Anthem BCBS and UHC only)

Your plan covers specialty drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient facility when they are covered services. This may include specialty drugs for infusion therapy, chemotherapy, blood products, certain injectable, and any drug that must be administered by a provider. This section applies when a provider orders the drug and a medical provider administers it to you in a medical setting. Specialty drugs that you can administer to yourself (or a caregiver may administer to you) are not covered under the medical benefit. Specialty drugs you get from a retail or mail order pharmacy are also not covered under your medical benefit.

Precertification is required for certain medically administered specialty drugs to help make sure proper use and guidelines for these drugs are followed. Your provider will submit clinical information, which will be reviewed for decision. Anthem BCBS or UHC, as applicable, will give the results of its decision to both you and your provider by letter.

For a list of medically administered specialty drugs that need precertification, please call the phone number on the back of your medical plan Identification Card. The precertification list is reviewed and updated from time to time. Including a specialty drug on the list does not guarantee coverage under your plan. Your provider may check with either Anthem BCBS or UHC, as applicable, to verify specialty drug coverage, to find out which drugs are covered under this section and if precertification is required.

Orthopedic treatment decision support

If you complete orthopedic treatment decision support ("treatment decision support" or "TDS") and use a designated facility for eligible spine (back) and joint (knees and hips) inpatient surgery (or for Aetna and UHC, certain outpatient surgeries), the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an in-network provider that is not a designated facility or you have not completed TDS (even if you use an in-network provider or a designated facility), the plan pays 80% of eligible expenses after you satisfy the annual deductible. **There is no coverage for inpatient services received from out-of-network providers. The plan pays 50% of eligible expenses after you satisfy the annual deductible for outpatient services received from out-of-network providers.**

Contact your claims administrator before scheduling your surgery to see if this program is right for you. Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant's spine (back) and joint (knees and hips) inpatient surgery (or for Aetna and UHC, certain outpatient surgeries).

Description	Anthem BCBS	Aetna	UnitedHealthcare
24-hour NurseLine Registered nurses available 24 hours a day, 365 days a year to help you understand a medical problem, evaluate self-care possibilities, and research treatment options	X	X	X
Autism Spectrum Disorder (ASD) support Provides a single point of contact to help members connect with available programs and resources, and works closely with our other clinical and customer services teams to ensure families impacted by autism have access to the right care and information	X	X	X
Bariatric surgery support Provides clinical support before and after weight loss surgery	X	X	X
Behavioral health resources Licensed mental health case managers are available to help you take control of your health care, improve your quality of life, and provide support to you and your family.	X	X	X
Cancer support Nurses provide support services to help those dealing with cancer	X	X	X
Complex case management Nurses provide support for those dealing with serious and complex health issues	X	X	X
Disease management Helps those with a chronic medical condition such as asthma, diabetes, and heart disease to better understand and manage those conditions	X	X	X
2nd.MD — second medical opinion Employees have access to a second medical opinion service, 2nd.MD, at no additional cost where can you get answers to your questions from medical experts through a video or phone consultation	X	X	X
Maternity support Program to support normal and high-risk pregnancies	X	X	X

Description	Anthem BCBS	Aetna	UnitedHealthcare
Medical Rx specialty management	X		X
Real Appeal program	X	X	X
Orthopedic treatment decision support For eligible spine (back) and joint (knees and hips) inpatient surgery (or for Aetna and UHC, certain outpatient surgeries)	X	X	X
Web-based tools and resources Online tools, resources, and programs that can help you make healthier lifestyle choices	X	X	X

Check with your applicable claims administrator for program specifics.

Pre-service authorization requirements

You are required to receive pre-service authorization from the claims administrator before receiving certain services. The claims administrator may also refer to this process as pre-authorization, pre-approval, prior approval, prior authorization, pre-notification, pre-certification, or pre-auth.

If you receive services from an in-network provider, the provider should request the authorization on your behalf. However, it's your responsibility to ensure that the required pre-service authorization has been received from the applicable claims administrator before you receive services. You should check with both your provider and the claims administrator before you receive services to ensure that the proper pre-service authorization is in place.

If you receive services from an out-of-network provider, you are responsible for obtaining pre-service authorization. If you do not receive the required authorization or approval before services are received and the services do not meet coverage criteria or are not deemed by the claims administrator to be a covered health service or eligible expense, you are responsible for all charges incurred. The charges do not count toward your annual deductible or your out-of-pocket coinsurance maximum and if you are enrolled in the Copay Plan with HRA, you cannot use your HRA dollars to pay for these charges.

If you do not receive the required authorization or approval before the following out-of-network services are received, your benefits will be reduced by 20% of eligible expenses if the claims administrator determines the services are covered health services:

- Dental care services and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
- Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item)
- Home health care services
- Home infusion therapy services
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Transplant services

The 20% reduction does not count toward the annual deductible or the annual out-of-pocket maximum. And, if you are enrolled in the Copay Plan with HRA, you cannot use your HRA dollars to pay for the additional 20% that becomes your responsibility.

When you request pre-service authorization for a nonurgent care service, the claims administrator will make an initial determination within 15 calendar days as long as all information reasonably needed to make a decision has been provided. This time period may be extended for an additional 15 calendar days, provided that the claims administrator determines that such extension is necessary due to matters beyond its control. If such extension is necessary, you will be notified before the expiration of the initial 15-day period.

When you request pre-service authorization for an urgent care service, the claims administrator will make an initial determination within 72 hours, as long as all information reasonably needed to make a decision has been provided. If you have not provided all necessary information, you will be notified of this within 24 hours. You will then be given 48 hours to provide the requested information. You will be notified of the benefit determination within 48 hours after the claims administrator receives the complete information or at the end of the time granted to the claimant to provide the specified additional information, whichever is earlier.

More information on pre-service authorizations (pre-service claims) can be found in "Appendix A: Claims and Appeals" in this *Benefits Book*.

Each claims administrator has a list of services that are subject to pre-service authorization. Refer to the list below or contact your claims administrator for information about what services may require pre-service authorization.

UnitedHealthcare

For pre-service authorization, contact UnitedHealthcare at 1-800-842-9722. Pre-service authorization is subject to UnitedHealthcare medical policy located at myuhc.com. Generally, medical policy is based on medically necessary criteria, which are described below.

Medically necessary – health care services that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be all of the following:

- In accordance with *Generally Accepted Standards of Medical Practice*.

  Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

  If no credible scientific evidence is available, then standards that are based on Physician Specialty Society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply Physician Specialty Society recommendations, the choice of expert, and the determination of when to use any such expert opinion shall be within UnitedHealthcare's sole discretion.

  UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards, and clinical guidelines supporting its determinations regarding specific services.
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for your sickness, injury, mental illness, substance use disorder, disease, or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service, or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease, or symptoms.

The following list of services is subject to pre-service authorization to ensure services meet coverage criteria. This list of services is subject to change in accordance with UnitedHealthcare medical policy. You may also call UnitedHealthcare Member Services for the most current list.

- Air ambulance — non emergent
- Approved fetal interventions
- Arthoplasty
- Arthroscopy (shoulder, elbow, hip, knee)
- Bariatric surgery
- Bone growth stimulation
- BRCA testing (genetic testing for breast cancer susceptibility)
- Cancer treatment services received through the Cancer Resource Services program
- Cardiac imaging or stress tests
- Cardiac rehabilitation services
- Cartilage implants
- Cerebral seizure monitoring inpatient video (Electroencehalogram (EEG)) when inpatient
- Certain spine (back) and joint (knees and hips) procedures
- Chemotherapy Services (specifically injectable Rx rendered by an MD that require PA)
- Clinical trials
- Cochlear implants and other auditory implants
- Congenital heart disease services under the Congenital Heart Disease (CHD) services program
- Congenital heart disease surgical interventions
- CT or CAT scans
- Dental and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth; temporomandibular joint (TMJ) surgical procedures; and orthognathic surgery
- Diagnostic cardiac catheterization
- Dialysis (outpatient)
- Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
- Electrophysiology implant
- Extended skilled nursing services
- Fetal echocardiograms
- Foot surgery
- Functional endoscopic sinus surgery (FESS)
- Genetic and molecular testing
- Heart catheterization
- Home health care services
- Home infusion therapy services
- Hospice care
- Hysterectomy
- Infertility and fertility services and treatments
- Inflammatory injectable medications

- Injectable medications (a drug capable of being injected intravenously through an intravenous infusion, subcutaneously, or intramuscularly)
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Intensity modulated radiation therapy
- Interventional cardiac catheterizations
- Maternity services if stay exceeds the 48-hour or 96-hour guidelines (including stays for a newborn that continue after the mother has been discharged)
- Medical specialty drugs administered by a medical provider (for more information see the "Medical specialty drugs administered by a medical provider (Anthem BCBS and UHC only)" starting on page 2-43)
- MR-guided focused ultrasound
- MRI or MRA scans
- Nonemergent ambulance services
- Nuclear medicine services
- Oncology services received through the Cancer Resource Services program
- Out-of-network outpatient surgery
- Outpatient sleep studies, including associate lab and x-ray services
- PET scans
- Prescription drugs that require administration under the direct supervision of a health care professional
- Prosthetic device that costs $1,000 or more
- Proton beam therapy
- Reconstructive surgery or procedures
- Sinuplasty
- Skilled nursing facility stays
- Sleep apnea procedures and surgeries
- Spine surgeries
- Temporomandibular joint (TMJ) disorder surgery
- Therapeutics (outpatient)
  - Dialysis
  - IMRT
  - MR-guided focused ultrasound
  - IV infusion
  - Radiation oncology
- Transplant services
- Vagus nerve stimulation
- Vein procedures
- Ventricular assist devices

You are required to obtain pre-service authorization for the services listed below before receiving these services from an out-of-network provider. Failure to follow the UnitedHealthcare pre-service authorization procedures for the following out-of-network services will result in a 20% reduction of the amount otherwise payable for eligible services:

- Dental care services and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
- Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
- Home health care services
- Home infusion therapy services
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Transplant services

The 20% reduction does not count toward the annual deductible or the annual out-of-pocket maximum. And, if you are enrolled in the Copay Plan with HRA, you cannot use your HRA dollars to pay for the additional 20% that becomes your responsibility.

Anthem BCBS

For pre-service authorization, contact Anthem BCBS at 1-866-418-7749 or by fax at 1-800-241-5308. It is recommended that you or the provider contact Anthem BCBS at least 15 business days before receiving the care to determine if the services are eligible.

Anthem reserves the right to determine whether a service or supply is medically necessary. The fact that a physician has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it medically necessary. Anthem considers a service medically necessary if it meets all of the following conditions:

- Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition.
- Compatible with the standards of acceptable medical practice in the United States.
- Not provided solely for your convenience or the convenience of the physician, health care provider, or hospital.

- Not primarily custodial care.
- Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

The following list of services is subject to pre-service authorization to ensure services meet coverage criteria. This list of services is subject to change in accordance with Anthem BCBS medical policy located at anthem.com. You may also call Anthem BCBS Member Service for the most current list.

- Acute inpatient rehabilitation
- Air ambulance — non emergent
- Bariatric procedures
- Carotid, vertebral, and intracranial artery angioplasty with or without stent placement
- Certain spine (back) and joint (knees and hips) procedures
- Cord blood, peripheral stem cell, and bone marrow procedures
- Cryosurgical ablation of solid tumors outside the liver
- CT or CAT scans
- Dental and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
- Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
- Extended skilled nursing care
- Home health care services
- Hospice care (inpatient and outpatient)
- Infertility and fertility services and treatments
- Inpatient hospital, inpatient treatment, intensive outpatient, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Intensity Modulated Radiation Therapy (IMRT)
- Long-term acute care facilities
- Maternity services if stay exceeds the 48 hours for normal delivery and 96 hours after a cesarean delivery
- Medical specialty drugs administered by a medical provider (for more information see the "Medical specialty drugs administered by a medical provider (Anthem BCBS and UHC only)" starting on page 2-43)
- MRA, MRI, or MRS scans
- Nuclear or cardiac imaging
- PET scans
- Proton beam therapies
- Radiofrequency ablation to treat tumors outside the liver
- Reconstructive surgery or procedures
- Skilled nursing facility stays
- Certain specialty pharmacy drugs covered under the medical plan; an additional review may be required for place of care where the drug will be administered
- Stereotactic radio surgery or stereotactic body radiation therapy
- Transcranial magnetic stimulation (TMS)
- Transplant services

You are required to obtain pre-service authorization for the services listed below before receiving these services from an out-of-network provider. Failure to follow the Anthem BCBS pre-service authorization procedures for the following out-of-network services will result in a 20% reduction of the amount otherwise payable for eligible services:

- Dental care services and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
- Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
- Home health care services
- Home infusion therapy services
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Transplant services

The 20% reduction does not count toward the annual deductible or the annual out-of-pocket maximum. And, if you are enrolled in the Copay Plan with HRA, you cannot use your HRA dollars to pay for the additional 20% that becomes your responsibility.

Aetna

Pre-service authorization is subject to Aetna medical policies located at aetna.com. Generally, medical policy is based on medically necessary criteria, which are described below.

Medically necessary care — Health care services that are appropriate in terms of type, frequency, level, setting, and duration to your diagnosis or condition, diagnostic testing, and preventive services. Medically necessary care, as determined by Aetna, must be:

- Appropriate for the symptoms, diagnosis, or treatment of your medical condition
- Consistent with evidence-based standards of medical practice where applicable
- Not primarily for your convenience or that of your family, your physician, or any other person
- The most appropriate and cost-effective level of medical services or supplies that can be safely provided

When the medically necessary criteria are applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting, as determined by Aetna.

A partial listing of services subject to pre-service authorization is provided below; however, it is not an exhaustive list and it is subject to change. Please be sure to check aetna.com or call Member Services at the number on the back of your ID card to determine if the service you are requesting requires pre-service authorization.

If you are receiving your care from an in-network provider, your physician will coordinate the pre-service authorization process for any services that must first be authorized. If you are receiving your care out-of-network, it is your responsibility to notify Aetna for pre-certification to ensure services meet coverage criteria.

- Air ambulance — non emergent
- Bariatric surgery
- Blepharoplasty or ptosis repair
- Certain spine (back) and joint (knees and hips) procedures
- Continuous passive motion devices (after 42 days of rental)
- Dental and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
- Durable medical equipment that costs $1,000 or more and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
- Eye surgery — refractive (including Intacs)
- Habilitative therapy: speech, physical, and occupational therapy
- Home health care services
- Home infusion therapy services
- Hospice care (inpatient and outpatient)
- Hospital beds (starting with the fourth month of rental and prior to the purchase of the item)
- Infertility and fertility services and treatments
- Injectable drugs administered in a clinic
- Injections for low back pain
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Mobile cardiac outpatient monitoring and implantable loop recorders
- New technology
- Reconstructive surgery or procedures
- Sclerotherapy
- Skilled nursing facility stays
- Transcranial magnetic stimulation (TMS)
- Transplant services
- Uvulopalatoplasty (UPPP)
- Wheelchairs (starting with the fourth month of rental for manual wheelchairs)

You are required to obtain pre-service authorization for the services listed below before receiving these services from an out-of-network provider. Failure to follow the Aetna pre-service authorization procedures for the following out-of-network services will result in a 20% reduction of the amount otherwise payable for eligible services:

- Dental care services and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
- Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
- Home health care services
- Home infusion therapy services
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Transplant services

The 20% reduction does not count toward the annual deductible or the annual out-of-pocket maximum. And, if you are enrolled in the Copay Plan with HRA, you cannot use your HRA dollars to pay for the additional 20% that becomes your responsibility.

Covered health services definition

The claims administrator has the complete and discretionary authority to determine what a covered health service is, based on the following:

1. Specific provisions stated in this chapter of the *Benefits Book*.
2. The applicable claims administrator's medical policy or coverage guidelines used by the claims administrator; these documents can be obtained by contacting your claims administrator (see the "Contacts" starting on page 2-4).

Note: When more than one provision, definition, or policy can apply, as determined by the claims administrator, **the most restrictive will apply and exclusions and limits supersede**.

Note: Effective January 1, 2022, if there is a conflict between the provisions of this booklet and the provisions of Section 7 of ERISA as amended by the Consolidated Appropriations Act of 2021 ("CAA Provisions"), the Plan's (and its Claims Administrator's) interpretation of the CAA provisions (and as set forth in any subsequently issued summary of material modifications) will control.

In the absence of specific provisions in this chapter or an applicable claims administrator medical policy or coverage guidelines used by the claims administrator, the claims administrator has the discretion to determine what a covered health service is, including services for the purpose of preventing, evaluating, diagnosing, or treating a sickness, an injury, mental illness, substance abuse, or their symptoms. To be a covered health service, the claims administrator must determine that the service is medically appropriate and:

- Necessary to meet the basic health needs of the participant.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply.
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations, or governmental agencies that are accepted by the utilization review organization or claims administrator.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the participant or his or her physician.
- In accordance with generally accepted standards of medical practice, as determined by the claims administrator. For these purposes, "generally accepted standards of medical practice" means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors, resulting in the conclusion that the service or supply is:
  - Safe and effective for treating or diagnosing the condition or sickness for which its use is proposed.
  - Safe with promising efficacy for treating a life-threatening sickness or condition in a clinically controlled research setting and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. (Life-threatening is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)
- Not listed in any "Not covered" or "Exclusions" section.

Covered health services must be provided when all of the following conditions are met:

- The medical plan is in effect.
- Before the effective date of any of the individual termination conditions set forth in this chapter.
- When the person who receives services is enrolled in and meets all eligibility requirements specified in the health plan.
- The treating health care professional or facility is licensed or certified under state law to provide the health care services rendered and is acting within the scope of their licensureship or certification.

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies.

Note: That a physician has performed or prescribed a procedure or treatment or that it may be the only treatment for a particular injury, sickness, mental illness, or pregnancy does not mean that it is a covered health service as defined here. This definition of a covered health service relates only to the coverage under your medical plan and differs from the way in which a physician engaged in the practice of medicine may define necessary care.

Eligible expenses (allowed amount) definition

The eligible expense or allowed amount is the maximum amount on which benefits are determined for covered health services. If your provider charges more than the allowed amount, you may have to pay the difference. Amounts above the allowed amount do not count toward the annual deductible or the annual out-of-pocket maximum.

You may obtain copies of the claims administrator's reimbursement policy for yourself or to share with your non-network physician or provider. These policies are available on the claims administrator's website or by calling the telephone number on your ID card.

UnitedHealthcare administered medical plans

Eligible expenses, also known as allowed amounts or eligible covered expenses, are determined as follows:

- According to UnitedHealthcare's reimbursement policy guidelines. These policy guidelines are developed, in UnitedHealthcare's sole discretion, in accordance with one or more of the following methodologies:
  - As indicated in the most recent edition of the *Current Procedural Terminology* (CPT), a publication of the American Medical Association or the *Centers for Medicare and Medicaid Services* (CMS)

- As reported by generally recognized professionals or publications
- As used for Medicare
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts

Regardless of provider network status, you will typically be required to pay a portion of the maximum allowed amount for covered services to the extent you have not met your deductible or have a copayment or coinsurance.

When covered health services are received from in-network providers, eligible expenses are UnitedHealthcare's contracted fees with that provider. Your in-network provider may not bill you for amounts above the eligible expense for covered health services (that is the difference between the contracted rate and the billed charge). You are responsible for any charges associated with services the plan does not cover. Charges for services not covered by the plan do not apply toward the annual deductible or annual out-of-pocket maximum.

If you are enrolled in the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, or Flex HDHP, when covered health services are received from out-of-network providers, your out-of-network provider may bill you for the amounts above the eligible expense, as determined by UnitedHealthcare; including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You are also responsible for any charges associated with services the plan does not cover. These amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.

- For emergency health services, UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an emergency health service. If the methodology currently in use becomes no longer available, UnitedHealthcare will use a comparable methodology. UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

  Regardless, the methodology will comply with the requirements of the affordable care act with respect to out of network emergency services.

- *Eligible expenses under the Shared Savings Program.*

  The Shared Savings Program is a program in which UnitedHealthcare may obtain a discount to an out-of-network provider's billed charge. Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to out-of-network providers who have agreed to discounted costs for services (in comparison to the provider's typically billed charge for the particular service). This discount is usually based on a schedule previously agreed to by the out-of-network provider. When this happens, you may experience lower out-of-pocket amounts. The plan's annual deductible and coinsurance still apply to the reduced charge.

  Sometimes plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case, the out-of-network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens, you should call the number on your ID Card. Shared Savings Program providers are not in-network providers and are not credentialed by UnitedHealthcare.

Anthem BCBS administered medical plans

This section describes how Anthem BCBS determines the eligible expense or maximum allowed amount for covered services. The maximum allowed amount may vary depending upon whether the provider is an in-network provider or an out-of-network provider.

- When covered health services are received from in-network providers, eligible expenses are Anthem BCBS's contracted fees with that provider. Your in-network provider may not bill you for amounts above the maximum allowed amount (eligible expense) for covered health services that is the difference between the contracted rate and the billed charge if different.

  You are responsible for any charges associated with services the plan does not cover. Charges for services not covered by the plan do not apply toward the annual deductible or annual out-of-pocket maximum.

- When covered health services are received from out-of-network providers and you receive emergency services from an out-of-network provider with whom Anthem does not have a direct contract, the maximum allowed amount (eligible expense) will be one of the methods described below, as determined by the claims administrator at its sole discretion:
  - An amount based on the claims administrator's out-of-network provider fee schedule or rate, which the claims administrator has established at its discretion, and which the claims administrator reserves the right to modify from time to time, after considering one or more of the following:
    - Reimbursement amounts accepted by like or similar providers contracted with the claims administrator
    - Reimbursement amounts paid by the Centers for Medicare and Medicaid Services (CMS) for the same services or supplies
    - Other industry cost, reimbursement, and utilization data
  - An amount based on reimbursement or cost information from the CMS. When basing the maximum allowed amount upon the level or method of reimbursement used by CMS, the claims administrator will update such information, which is unadjusted for geographic locality, no less than annually. If a professional claim amount is determined based on CMS, the reimbursement amount will be based on 140% of national Medicare rates unadjusted for geographic locality.

- An amount based on information provided by a third party vendor, acceptable to the claims administrator, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Provider's fees and costs to deliver care.
- An amount negotiated by the claims administrator or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management.
- An amount based on or derived from the total charges billed by the out-of-network provider.
- For covered services rendered outside the claims administrator's service area by out-of-network providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule/rate or the pricing arrangements required by applicable state or federal law. In certain situations, the maximum allowed amount for out of area claims may be based on billed charges, the pricing the plan would use if the healthcare services had been obtained within the claims administrator's service area, or a special negotiated price.

Except for surprise billing claims, when you use an out-of-network provider, you are responsible for paying any difference between the maximum allowed amount and the provider's actual charges. You are also responsible for any charges associated with services the plan does not cover. These charges do not apply toward the annual deductible or annual out-of-pocket maximum. If you receive emergency services from an out-of-network provider, covered services will be processed at the network benefit level.

- The maximum allowed amount (eligible expense) for emergency care (for a life-threatening medical emergency or serious accidental injury) from an out-of-network provider will be the greatest of the following:
  - The amount negotiated with network providers for the same type of emergency service furnished
  - The amount for the emergency service calculated using the same method the claims administrator generally uses to determine payments for out-of-network services but substituting the network cost-sharing provisions for the out-of-network cost-sharing provisions
  - The amount that Medicare would reimburse the provider for the emergency care
  - Regardless, the methodology will comply with the requirements of the No Surprises Billing Act and the Affordable Care Act (ACA) with respect to out-of-network emergency services.

Aetna administered account-based medical plans

Eligible expenses, also known as allowed amounts or eligible covered expenses and may be referred to by Aetna as "recognized charges," are determined as follows:

- When covered health services are received from in-network providers, eligible expenses are the provider's discounted contracted fees. Some procedures may require using a dedicated Aetna network, such as Institutes of Quality for bariatric surgery or Institutes of Excellence for certain infertility services.
- When covered health services are received as a result of an emergency (or as arranged by Aetna) from an out-of-network provider with whom Aetna has a direct contract (but the provider is not a network provider), eligible expenses are an amount negotiated by Aetna or otherwise determined by Aetna, in its discretion, based on a number of factors including geographic area and Aetna reimbursement policy. Your out-of-network provider may bill you for the amounts above the eligible expense; these amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.
- If you are enrolled in the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, or Flex HDHP, when covered health services are received from out-of-network providers, or if you are enrolled in the Narrow Network Plan with HSA or Narrow Network Copay Plan and receive emergency services from an out-of-network provider with whom Aetna does not have a direct contract, eligible expenses are based on the geographic area (as determined by Aetna) where you receive the service or supply and Aetna reimbursement policies. The eligible expense is the lesser of what the provider bills and one of the following:
  - 140% of the Medicare allowed amount for hospital and facility charges
  - 110% of the Medicare allowed amount for professional services and other services and supplies

  For other charges for which there is no Medicare allowed amount, the eligible expense is calculated according to the allowed amount for a given service or item, as determined by Aetna. Your out-of-network provider may bill you for the amounts above the eligible expense; these amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.
- Aetna's reimbursement policy guidelines also apply. The reimbursement policy guidelines are developed, in Aetna's discretion, based on review of one or more of the following methodologies:
  - The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
  - The most recent edition of the *Current Procedural Terminology* (CPT), a publication of the American Medical Association
  - The views of physicians practicing in relevant clinical areas (in some cases commercial software is used)
  - Decisions made by medical staff and outside medical consultants pursuant to other appropriate source or determination that the claims administrator accepts

Services covered under the medical plans

The medical plans cover certain services for illness, injury, and pregnancy. Coverage is not necessarily limited to services and supplies described in this section — unlisted services may not, however, be covered. If you have questions about coverage, call your claims administrator. (Also, see the "Covered health services definition" section starting on page 2-50 for more information.)

The services and cost-sharing amounts on the following pages are subject to the limitations, exclusions, and procedures described in this chapter. When more than one definition or provision applies to a service, the most restrictive applies and exclusions and any other stated limits take precedence over general benefits descriptions.

Whether you will pay a copay or coinsurance for covered health services depends on how your provider codes the claim. Your provider will include diagnosis codes, procedure codes, and identifying provider information on the claim submitted to the claims administrator for processing.

- An office visit copay only applies to the charge coded as an office visit.
  - Whether you pay the PCP office visit copay or the specialist office visit copay is contingent on how the provider's identifying information is noted within the claims administrator's claims processing system.
- All other charges for services are subject to the applicable annual deductible and coinsurance.

Coinsurance is based on eligible expenses for covered health services. In addition to the copay or coinsurance you pay for covered health services, you must pay for all charges not covered by your medical plan. Any coinsurance amount listed applies after the annual deductible is met (except for in-network preventive care). The annual deductible is referred to as "deductible" in the cost-sharing tables that follow, beginning on page 2-54. Unless otherwise noted, the in-network annual deductible must be met for services received from an in-network provider and the out-of-network annual deductible must be met separately for services received from an out-of-network provider. For more information about the annual deductible, see the "Important terms" section starting on page 2-12.

It's also important to note that the medical plans only cover care provided by health care professionals or facilities licensed, certified, or otherwise qualified under state law to provide health care services and acting within the scope of their licensureship or certification. For more information on providers, see the "Providers and provider networks" section starting on page 2-9.

Acupuncture

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $25 copay for an office visit with a primary care physician[2, 3] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay a $25 copay for an office visit with a primary care physician.[2, 3, 4] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit with a primary care physician.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge. Benefits are limited to 26 visits per plan year.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover acupuncture services received from a licensed or certified physician, chiropractor, or acupuncturist acting within the scope of that license or certification, limited to 26 visits per plan year, in-network and out-of-network services combined.

Covered health services include services needed for pain therapy. Covered health services also include treatment for nausea as a result of the following:

- Chemotherapy
- Pregnancy
- Postoperative procedures

Not covered

All other acupuncture services.

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

UnitedHealthcare and Anthem BCBS:

If a service is performed by a chiropractor, it will be applied to the 26-visit chiropractic benefit limit.

If you move during the plan year, resulting in a change in your claims administrator, the 26-visit limit per plan year will start over under the new claims administrator.

Ambulance

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the in-network deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the in-network deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

The medical plans cover the following types of professional ambulance services:

- Ambulance service from the place of emergency departure to the nearest local hospital, required for stabilization and initiation of treatment as provided under the direction of a physician in an emergency situation.
- Air ambulance to the nearest facility qualified to give the required treatment, as determined by the claims administrator, when ground ambulance transportation is not medically appropriate because of the distance involved or because the covered patient has an unstable condition requiring medical supervision and rapid transport.

This would include transportation, if needed in a foreign country, to transport to the nearest facility qualified to treat the patient as determined by the claims administrator.

Note: In cases where pre-authorization is not obtained or where the claims administrator has determined that air transport is not covered (for example, because it is not medically necessary) no amount will be allowed for air transport and you will be responsible for any air ambulance charges. This could occur, for example, where air transport is directed to a facility other than the facility approved by the claims administrator.

- Ambulance transport to a hospital at the next level of acute care services, for example, a skilled nursing facility or rehabilitation facility (does not include transport to custodial care or facility, or transport to a residence).
- Ambulance transport from a skilled nursing facility or rehabilitation facility to another facility or hospital for tests or diagnosis when such tests or diagnostics cannot be rendered at the initial facility.

Not covered

- Air ambulance services that are not approved by the claims administrator. Air ambulance will not be covered if you are not taken to an acute care hospital, for example, but not limited to, a rehabilitation facility, a physician's office, or a residence.
- Nonemergency services, except as noted on page 2-56.
- Transportation services that are not necessary for basic or advanced life support.
- Transportation services that are mainly for your convenience.

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

Nonemergent ambulance services are subject to pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-45 for more information).

Autism coverage

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $25 copay for an office visit.[2, 3] For services billed separately from the office visit charge (including ABA and IBT), you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay a $25 copay for an office visit.[2, 3, 4] For services billed separately from the office visit charge (including ABA and IBT), you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The office visit copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to ABA and IBT, diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge, including ABA and IBT.	No coverage.	No coverage.

1. The deductible does not apply.

2. The office visit copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, including ABA and IBT, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover Applied Behavioral Analysis (ABA) Intensive Behavioral Therapy (IBT) for enrolled participants and dependents diagnosed with autism and autism spectrum disorders. ABA IBT is behavioral therapy focused on primarily building skills and capabilities in communication, social interaction, and learning services. **It is strongly recommended that you call the applicable claims administrator before receiving services** to ensure that the services you seek are covered under the plan. In addition, you can get information about in-network providers available in your area. Please note that inpatient hospital treatment or other inpatient medical facility admissions, such as residential treatment or structured outpatient care, which is considered a form of inpatient care, require pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-45 for more information).

Generally, covered services include:

- Diagnostic evaluations and assessment
- Treatment planning
- Referral services
- Medical management
- Inpatient or 24-hour supervisory care, or both
- Partial hospitalization, day treatment, or both
- Intensive outpatient treatment
- Services at a Residential Treatment Facility
- Individual, family, therapeutic group, and provider-based case management services
- Psychotherapy, consultation, and training session for parents and paraprofessional, and resource support to family
- Crisis intervention
- Transitional care

Not covered

- Tuition for school-based programs for autism and autism spectrum disorders
- Any related supplies or equipment associated with the treatment of autism, other than ABA IBT as previously noted, even if the supplies or equipment are recommended or prescribed by a physician

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

For services coded as an office visit (excluding ABA IBT services), refer to the "Outpatient mental health and substance abuse office visits and other services (in-person or virtual)" section starting on page 2-105.

Bariatric services

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. You pay: • $25 copay for an office visit with a primary care physician[2, 3] • $45 copay for an office visit with a specialist[2, 3]	No coverage.	For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. You pay: • $25 copay for an office visit with a primary care physician[2, 3, 4] • $45 copay for an office visit with a specialist[2, 3, 4]

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible if services are received at a designated facility.	No coverage.	You pay 20% of eligible covered expenses after you satisfy the deductible if services are received at a designated facility.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible if services are received at a designated facility.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit with a primary care physician.[1, 2] • $45 copay for an office visit with a specialist.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover gastric bypass or lap band surgery if specific criteria are met. Bariatric surgery, also known as weight loss surgery, refers to the various surgical procedures performed to treat people living with morbid or extreme obesity. It may be an effective treatment for weight loss for those who have not experienced long-term weight loss success through other means.

For the Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, and the Flex HDHP, services must be received at a designated facility. The medical policy or coverage criteria of the claims administrator are used to determine eligibility for coverage. Contact your claims administrator before receiving services for specific criteria and pre-service authorization. For more information on inpatient hospital stays, see the "Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)" section starting on page 2-84. For more information on outpatient surgery, see the "Outpatient surgery, diagnostic, and therapeutic services" section starting on page 2-107.

Not covered

- All other weight loss-related services, supplies, or treatments, including weight loss programs, health clubs, or spas
- Experimental, investigational, or unproven services
- Food, food substitutes, or food supplements of any kind (such as diabetic, low-fat, or low-cholesterol)
- Megavitamin and nutrition-based therapy
- Oral vitamins and oral minerals
- Removal of excess skin or fat, or both, when the procedure does not meet the claims administrator's medical criteria

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

UnitedHealthcare:

Enrollment for the bariatric services program must be initiated with Bariatric Resource Services before receiving services. Covered participants seeking coverage for bariatric surgery should call Bariatric Resource Services at 1-888-936-7246 to determine if they meet the criteria to enroll in the program. This is a comprehensive program that requires patients to meet established UnitedHealthcare Bariatric Surgery medical policy and also requires presurgery psychological evaluation. In order for surgery to be covered, compliance with all components of the bariatric services program is required.

After the member is enrolled, the Optum Care Advocate from the Bariatric Outreach Unit will coordinate ongoing psychological care with United Behavioral Health network providers and a designated facility. The mental health benefits provisions apply to any psychological care received. See the "Outpatient mental health and substance abuse office visits and other services (in-person or virtual)" section starting on page 2-105 for coverage details.

All bariatric services, including nutritional counseling, must be received at a designated Center of Excellence facility to be covered. Any services received outside of a designated facility are not covered and no benefits will be paid. A designated Center of Excellence facility may or may not be located within your geographic area. Depending on the location of the designated facility, you may be eligible for reimbursement of a portion of transportation and lodging. The services described in the "Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery" starting on page 2-132 are covered health services only in connection with the program's morbid obesity bariatric services received at a designated facility after enrollment in the program.

A designated facility has entered into an agreement with UnitedHealthcare, or with an organization contracting on behalf of the medical plan, to provide covered health services for the treatment of specified diseases or conditions. A designated facility may or may not be located within your geographic area. To be considered a designated facility, the facility must meet certain standards of excellence and have a proven track record of treating specified conditions as determined by UnitedHealthcare. Note that a facility is not necessarily considered a designated facility just because it's an in-network provider.

Anthem BCBS:

You must receive services from a Blue Distinction Center for Bariatric Surgery (a designated facility) in order for services to be covered. Note that a facility is not necessarily considered a designated facility just because it's an in-network provider.

If you are enrolled in a Narrow Network plan, Blue Distinction Centers provisions do not apply, but you do need to receive services from a designated Anthem Blue High Performance Network provider within the narrow network associated with your plan. Please refer to the "Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery" starting on page 2-132.

Exception: Members enrolled in the following medical plan options administered by Anthem BCBS are not required to receive services from a Blue Distinction Center and participating provider:

- Copay Plan with HRA Out of Area coverage only
- Higher Use Plan with HSA Out of Area coverage only
- Lower Use Plan with HSA Out of Area coverage only
- Flexible HDHP Out of Area Coverage Only

Aetna:

Members must use a Aetna designated network weight loss provider, and pre-service authorization is required before receiving services. Services are not covered if they are received from providers who are not Aetna designated network weight loss providers. Note that a facility is not necessarily considered a designated facility just because it's an in-network provider.

Through the Aetna network of providers, bariatric Institutes of Quality (IOQ) facilities provide the following services:

- Lap bands — device wrapped around upper part of stomach to make it smaller for less food intake
- Bypass — creation of a small pouch in the stomach that is connected directly to middle part of small intestine, bypassing the remainder of the stomach and upper small intestine
- Sleeve gastrectomy — removal of majority of stomach, creating narrow tube to decrease amount of food eaten and decrease amount of food absorbed

If you are enrolled in a Narrow Network plan, IOQ provisions do not apply, but you do need to receive services from Aetna designated network weight loss providers within the narrow network associated with your plan.

Refer to the "Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery" starting on page 2-132 for information about covered travel expenses related to bariatric surgery.

Chiropractic care and spinal manipulation

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $25 copay for an office visit with a primary care physician.[2, 3] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay a $25 copay for an office visit with a primary care physician.[2, 3, 4] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit with a primary care physician.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge. Benefits are limited to 26 visits per plan year.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover spinal treatment (including chiropractic and osteopathic manipulative therapy) when provided by a spinal treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day, 26 visits per plan year, in-network and out-of-network services combined. The medical plans also cover massage therapy that is performed in conjunction with other treatment or modalities by a provider licensed to render this service and is part of a prescribed treatment plan and not billed separately.

Not covered

- Massage therapy, except as noted on this page
- Therapy, service, or supply, including but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition that ceases to be therapeutic treatment, such as maintaining a level of functioning or preventing a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness such as asthma or allergies
- Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, or social disadvantages)
- Services for or related to educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting) and all related charges
- Services for or related to forms of nonmedical self-care or self-help training, including but not limited to health club memberships, aerobic conditioning, therapeutic exercises, and all related charges
- Services for or related to work-hardening programs or vocational rehabilitation and all related charges for these programs
- Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

If you move during the plan year, resulting in a change in your claims administrator, the 26-visit limit per plan year will start over under the new claims administrator.

Convenience care (in retail settings)

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $25 copay for a convenience care office visit.[2, 3] For services billed separately from the convenience care office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay a $25 copay for a convenience care office visit.[2, 3, 4] For services billed separately from the convenience care office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the convenience care office visit charge.** Certain treatments apply a copay when not billed as a convenience care office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for a convenience care office visit along with treatment that applies a copay, you will only be responsible for the convenience care office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your convenience care office visit, including but not limited to diagnostic services (for example, lab work), surgical services, or services performed by another physician or specialist brought into the convenience care office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the convenience care facility. If you receive other services or supplies during your convenience care office visit, those charges may be billed separately from the convenience care office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to service received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for a convenience care office visit.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the convenience care office visit charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the convenience care office visit charge.** Certain treatments apply a copay when not billed as a convenience care office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for a convenience care office visit along with treatment that applies a copay, you will only be responsible for the convenience care office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your convenience care office visit, including but not limited to diagnostic services (for example, lab work or supplies), surgical services, or services performed by another physician or specialist brought into the convenience care office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the convenience care facility. If you receive other services or supplies during your convenience care office visit, those charges may be billed separately from the convenience care office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover care received at a convenience clinic, also known as a retail health clinic. Convenience clinics typically treat minor health issues such as sore throats and ear and sinus infections. You will be directed to a clinic or hospital if you cannot be treated at a convenience clinic.

Note: A convenience clinic is not an urgent care center. For information on benefits related to urgent care, see the "Urgent Care Clinics" starting on page 2-133.

Not covered

Refer to the "Exclusions" section starting on page 2-137.

Dental care

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

The medical plans cover

Hospital-related dental services

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover certain hospital services (see the "Covered health services definition" section starting on page 2-50). Coverage is limited to charges incurred by a covered person who:

- Is a child under age five
- Is a child between the ages of five and 12 and where either of the following conditions is met:
  - Care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful
  - Extensive amounts of restorative care, exceeding four appointments, are required
- Is severely disabled
- Has one of the conditions listed below, requiring hospitalization or general anesthesia for dental care treatment:
  - Respiratory illnesses
  - Cardiac conditions
  - Bleeding disorders
  - Severe risk of compromised airway
  - The need for extensive procedures that prevent an oral surgeon from providing general anesthesia in the office setting, regardless of age
  - Psychological barriers to receiving dental care, regardless of age

The coverage is limited to facility and anesthesia charges. Oral surgeon or dentist professional fees are not covered. Covered health services are determined based on established medical policies, which are subject to periodic review and modification by the claims administrator's medical directors.

The medical plans also cover dental x-rays, supplies, and appliances, and all associated expenses, including hospitalizations and anesthesia necessary to:

- Prepare for transplant
- Initiate immunosuppressives
- Diagnose cancer
- Directly treat current instance of cancer

Accidental dental services

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover treatment received from a physician or dentist for an accidental injury to sound, natural teeth when performed within 12 months from the date of injury. Coverage is for damage caused by external trauma to face and mouth only.

Note: All eligible accidental dental services are covered at the in-network benefit level.

Treatment of cleft lip and cleft palate

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover treatment of cleft lip and palate for a dependent child under age 18.

Orthognathic surgery

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the plans cover orthognathic surgery that meets the claims administrator's medical policy criteria.

Oral surgery

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover certain outpatient oral surgery performed in the oral surgeon's office. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, nondental cysts, fracture of the jaws, and trauma of the mouth and jaws.

Temporomandibular joint disorder (TMJ)

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover the following:

- Services for nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, which include removable appliances for TMJ. Covered services do not include fixed or removable appliances that involve movement or repositioning of the teeth or operative restoration of the teeth or prosthetics.
- Orthognathic surgery is covered for the treatment of TMJ and craniomandibular disorder, as determined by the medical policy criteria of the claims administrator.

Not covered

The following dental care services are not covered regardless of whether they are medical or dental in nature:

- Accident-related dental services not performed within 12 months from the date of injury.
- Any dental procedure or treatment not listed as covered within this SPD.
- Dental services to treat an injury or cracked or broken teeth that result from biting or chewing.
- Dentures, regardless of the cause or the condition, and any associated services or charges, including bone grafts.
- Dental implants, regardless of the cause or the condition, and any associated services or charges, including bone grafts, and all associated expenses.
- Dental braces or orthodontia services and all associated expenses.
- Dental x-rays, supplies, and appliances, and all associated expenses, including hospitalizations and anesthesia, except as previously noted.
- Oral appliances except as needed for medical conditions affecting temporomandibular joint disorder (TMJ). See the "Temporomandibular joint disorder (TMJ)" section on this page for more information.
- Oral surgery and all associated expenses, including hospitalizations and anesthesia, except as previously noted.
- Procedures associated with the fitting of dentures (including osteotomies for this purpose).
- Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums, and all associated expenses, including hospitalizations and anesthesia, except as previously noted.
- Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly, and all associated expenses, including hospitalizations and anesthesia, except as previously noted.

Also, refer to the "Exclusions" section starting on page 2-137.

Durable medical equipment, supplies, and prosthetics

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

The medical plans cover

Pre-service authorization is required before obtaining any single item that costs $1,000 or more (purchase price or cumulative rental of a single item). See the "Pre-service authorization requirements" section starting on page 2-45.

The medical plans cover durable medical equipment and supplies that meet each of the following criteria:

- Ordered, prescribed, or provided by a physician for outpatient use for the patient's diagnosed condition
- Used for medical purposes
- Equipment, appliances, or devices that are not consumable or disposable
- Not of use to a person in the absence of a disease or disability
- For orthotic appliances and devices, that the items must be custom manufactured or custom fitted to the patient for diagnosed condition

If more than one piece of durable medical equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment.

Benefits are provided for the replacement of durable medical equipment when it can no longer be repaired to have it function at its original specifications. This will not be more often than once every three years unless there is a change in a covered person's medical condition that requires repairs or replacement sooner (for example, due to growth of a dependent child).

The medical plans also cover a single purchase, including repairs, of a prosthetic device that replaces a limb or body part, including artificial limbs and artificial eyes. The medical plans also cover breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device as determined by the applicable claims administrator. The prosthetic device must be ordered or provided by or under the direction of a physician.

Benefits are provided for the replacement of each type of prosthetic device when it can no longer be repaired to have it function at its original specifications. This will be not more often than every three years.

Covered durable medical equipment includes the following when the claims administrator's medical criteria are met:

- Appliances for snoring when provided as a part of treatment for documented obstructive sleep apnea
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces
- Braces to treat curvature of the spine
- Compression stockings or compression sleeves, when used for care related to the diagnosis of lymphedema or for edema in pregnancy
- Cranial bands and helmets for children up to 18 months old
- Delivery pumps for tube feeding
- Insulin pumps, pump supplies, and glucose monitors
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions
- Oxygen concentrator units and equipment rental to administer oxygen
- Shoe or foot orthotics
- Speech devices
- Standard hospital bed
- Wheelchairs (standard, electric, or custom) when ordered by a physician and medically necessary
- Wigs up to $500 per calendar year as deemed medically necessary by the claims administrator

Covered supplies include:

- Burn garments
- Ostomy supplies (pouches, face plates, and belts; irrigation sleeves, bags, and catheters; and skin barriers)
- Disposable urinary catheters
- Disposable wound vac
- Surgical dressings, casts, splints, trusses, crutches, and noncorrective contact lens bandages

Note: When women's preventive health care services such as contraceptive devices (including intrauterine devices, diaphragms, and implants) and breast feeding equipment are received from in-network providers, the pre-service authorization requirements in this durable medical equipment section do not apply. For more information on coverage of such services or supplies, see the "Women's preventive health care services" section starting on page 2-135.

Not covered

Items that are not eligible for coverage include, but are not limited to:

- Cranial bands, banding, remolding, and helmets for individuals 18 months or older
- Dental braces
- Items that can be obtained without a prescription or physician's order
- Devices used specifically as safety items or to affect performance in sports-related activities
- Prescribed or nonprescribed medical supplies and disposable supplies, including elastic stockings, ace bandages, gauze, and dressings, except as noted above
- Tubings, nasal cannulas, connectors, and masks, except when used with durable medical equipment
- Appliances for snoring except as previously noted for sleep apnea
- Oral or dental prosthesis, except as previously noted within the "Dental care" section starting on page 2-67 or as otherwise deemed medically necessary by the claims administrator
- Replacement or repair of any covered items, if the items are:
  - Damaged or destroyed by misuse, abuse, or carelessness
  - Lost
  - Stolen
- Duplicate or similar items
- Labor and related charges for repair of any covered items that are more than the cost of replacement by an approved vendor
- Sales tax, mailing and delivery, and service call charges
- The cost of an extended warranty or a service contract
- Items that are primarily educational in nature or for hygiene, vocation, comfort, convenience, or recreation
- Diets for weight control or treatment of obesity (including liquid diets or food)
- Food, food substitutes, or food supplements (such as diabetic, low-fat, low-cholesterol, or infant formula) unless specifically noted in this SPD
- Megavitamin and nutrition-based therapy
- Household equipment that primarily has customary uses other than medical

- Household fixtures, including but not limited to escalators or elevators, ramps, swimming pools, whirlpools, and saunas
- Modifications to the structure of the home, including but not limited to wiring, plumbing, or charges for installation of equipment
- Vehicle, car, or van modifications, including but not limited to hand brakes, hydraulic lifts, and car carriers
- Rental equipment while the covered person's owned equipment is being repaired, beyond one-month rental of equipment
- Other equipment and supplies, including but not limited to assistive devices that the claims administrator determines are not eligible for coverage
- Hearing aids or devices, whether internal, external, or implantable, and related fitting or adjustment, except as specified in this SPD (see the "Hearing aids" starting on page 2-77 for more information)
- Charges for purchase or replacement of eyeglasses, contact lenses, or other optical devices or professional services, including to fit or supply them, except as specifically described in this SPD
- Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs (see the "Prescription drug benefit" section starting on page 2-146 for information on diabetic supplies)
- Androgenetic alopecia related services — androgenetic alopecia is the most common form of hair loss encompassing conditions such as male pattern baldness or hair thinning
- Services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including but not limited to:
  - Air conditioners
  - Air purifiers
  - Computers and related equipment
  - Dehumidifiers
  - Exercise equipment
  - Feeding and bath chairs
  - Food or weight scales
  - Heat or cold appliances
  - Hot tubs or whirlpools
  - Hypoallergenic mattresses
  - Incontinence pads or pants
  - Pillows
  - Waterbeds
  - Water purifiers
- Oral or dental prosthesis, except as previously noted within the "Dental care" section starting on page 2-67

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

UnitedHealthcare:

Pre-service authorization is required before obtaining any single item of durable medical equipment that costs $1,000 or more (either purchase price or cumulative rental of a single item).

UnitedHealthcare covers a single unit of durable medical equipment (for example, one insulin pump), and provides repair for that unit. Benefits are provided for replacement of a type of durable medical equipment once every three years, unless there is a change in the covered person's medical condition that requires repair or replacement sooner (for example, due to growth of a dependent child).

Anthem BCBS:

Pre-service authorization is required for durable medical equipment that costs $1,000 or more (either purchase price or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase price or cumulative rental of a single item).

Aetna:

Durable medical equipment and supplies must be obtained from, or repaired by, approved vendors. Pre-service authorization is required for durable medical equipment or prosthetics that cost $1,000 or more (either purchase price or cumulative rental of a single item).

Emergency care

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses for emergency care after you satisfy the in-network deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the in-network deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses for emergency care after you satisfy the in-network deductible.	You pay 20% of eligible covered expenses after you satisfy the in-network deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the in-network deductible.	You pay 20% of eligible covered expenses after you satisfy the in-network deductible.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the in-network deductible.	You pay 20% of eligible covered expenses after you satisfy the in-network deductible.

The medical plans cover

The medical plans cover emergency care services for accidental injury and other medical emergencies treated in an emergency room if, in the judgment of a reasonable person, immediate care and treatment are required, generally within 24 hours of onset, to avoid jeopardy to life or health.

For ambulance or air ambulance services, see the "Ambulance" starting on page 2-56.

The medical plan also covers services received at an urgent care center. For more information see the "Urgent Care Clinics" starting on page 2-133.

Note: If you receive emergency services from an out-of-network provider, covered services will be processed at the in-network benefit level. Out-of-network providers may only bill you for any applicable copayments, deductibles, and coinsurance, and may not bill you for any charges over the Plan's maximum allowed amount until the treating out-of-network provider has determined that you are stabilized.

Not covered

- Nonemergency use of the emergency room, as determined by the claims administrator unless referred to the emergency room by your claims administrator's nurseline. This would include follow-up care done in an emergency room (for example, wound checks and suture removal).
- Nonemergency coverage while abroad or overseas.

Also, refer to the "Exclusions" section starting on page 2-137.

Extended skilled nursing care

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of- network services combined.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area coverage
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits.	No coverage.	No coverage.

The medical plans cover

With pre-service authorization before receiving services, the medical plans cover extended skilled nursing care. Extended skilled nursing care is defined as the use of skilled nursing services delivered or supervised by a registered nurse (RN) or licensed practical nurse (LPN) to obtain the specified medical outcome and provide for the safety of the patient. To be covered:

- An attending physician must order extended skilled nursing care.
- Certification of the RN or LPN providing the care is required.
- The claims administrator, in its sole discretion, must determine that the extended skilled nursing care is a covered health service.
- The covered person and the provider must obtain pre-service authorization from the claims administrator (see the "Pre-service authorization requirements" section starting on page 2-45).

Benefits are limited to 100 visits per plan year combined with home health care (the 100-visit maximum is for in-network and out-of-network services combined). Each 24-hour visit (or shifts of up to 24-hour visits) equals one visit and counts toward the 100 combined visits. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the 100-visit limitation (combined with home health care).

Services provided under the following circumstances will be considered extended skilled nursing services:

- Transition of the covered person from an inpatient setting to home.
- The covered person becomes acutely ill and the additional skilled nursing care may prevent a hospital admission.
- The covered person meets the clinical criteria for confinement in a skilled nursing facility, but a skilled nursing facility bed is not available. In this situation, additional skilled nursing may be provided until a skilled nursing facility bed becomes available.
- The covered person is on a ventilator or is dependent on continuous positive airway pressure due to respiratory insufficiency at home and whose condition shows frequent changes. Once the person's condition does not show the need for frequent changes, the extended skilled nursing is not needed.

Note: For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home, refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information and pre-service authorization requirements and instructions.

Not covered

- Nursing care that does not require the education, training, and technical skills of an RN or LPN.
- Nursing care provided for skilled observation.
- Nursing care provided while the covered person is an inpatient in a hospital or health care facility.
- Nursing care to administer routine maintenance medications or oral medications, except where law requires an RN or LPN to administer medicines.
- Custodial care for daily life activities, including but not limited to:
  - Transportation
  - Meal preparation
  - Vital sign charting
  - Companionship activities
  - Bathing
  - Feeding
  - Personal grooming
  - Dressing
  - Toileting
  - Getting in or out of bed or a chair
- Services that can be safely and effectively performed by a nonmedical person or self-administered without the direct supervision of a licensed nurse. The unavailability of a person to provide an unskilled service does not allow for coverage for a nurse to provide unskilled services.
- Private-duty nursing.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information.

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

If you move during the plan year, resulting in a change in your claims administrator, the 100-visit limit (combined with home health care) per plan year will start over under the new claims administrator.

Gender reassignment

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You pay a $25 copay for an office visit.[2, 3] You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You pay a $25 copay for an office visit.[2, 3, 4] You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The office visit copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: $25 copay for an office visit.[1, 2] 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

For gender reassignment surgery benefits, the criteria for diagnosis and treatment are based on the guidelines set forth by the World Professional Association for Transgender Health (WPATH). Covered health services are subject to the claims administrator's medical policy or clinical guidelines, and all other plan provisions. Note that not all WPATH recommended services are covered under this Plan. Gender reassignment surgery benefits are limited to one reassignment per covered person per lifetime.

Inpatient hospital services require pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). **However, it is strongly recommended that you call the applicable claims administrator before receiving any related services** to ensure that the services you seek are covered under the plan. In addition, you can get information about in-network providers available in your area. See the "Pre-service authorization requirements" section starting on page 2-45 for the contact information.

Generally, covered expenses include:

- Outpatient office visits (see the "Office visit — primary care physician (PCP) (in-person or virtual)" starting on page 2-100 and the "Outpatient mental health and substance abuse office visits and other services (in-person or virtual)" starting on page 2-105 for more information).
- Pre- and postsurgical hormone therapy covered under the pharmacy benefit (refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information and any pre-service authorization instructions).
- Facial feminization surgery (male to female), including but not limited to facial bone reduction, face "lift," facial hair removal, and certain facial plastic procedures.
- Hair removal (male to female) for skin grafting related to genital reconstruction.
- Hair transplant coverage for male to female gender reassignment.
- Genital surgery, surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty), and mastectomy scar revision for a female-to-male transition. Inpatient hospital services or treatment require pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-45 for more information).
- Voice modification surgery.
- Voice therapy.

Not covered

- Cosmetic surgery (except as previously noted for gender reassignment)
- Charges for services or supplies that are not based on the guidelines set forth by the WPATH as determined by the claim's administrator
- Cryopreservation of fertilized embryos
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Sperm preservation in advance of hormone treatment or gender surgery

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

Refer to the "Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery" section on page 2-132 for information about covered travel expenses related to gender reassignment surgery.

Hearing aids

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

The medical plans cover

The medical plans cover up to one hearing aid or set of hearing aids every three plan years.

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver. Benefits are available for a hearing aid that is prescribed by a physician or appropriate provider or clinician as determined by the claims administrator. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

The plans also cover external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the medical plan. Cochlear implantation can either be an inpatient or outpatient procedure. Check with your claims administrator for pre-service authorization requirements.

Post Cochlear Implant aural therapy is covered. Check with your claims administrator regarding any limitations.

Not covered

- Bone-anchored hearing aids, except as specifically described in the claims administrator's medical policy
- Hearing aid batteries, including but not limited to cochlear implant batteries

Also, refer to the "Exclusions" section starting on page 2-137.

Home health care

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care, in-network and out-of-network services combined.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care, in-network and out-of-network services combined.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care, in-network and out-of-network services combined.	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care, in-network and out-of-network services combined.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care, in-network and out-of-network services combined.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care.	No coverage.	No coverage.

The medical plans cover

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover certain home health care services limited to 100 visits per plan year by a home health care professional (the 100-visit maximum is for combined in-network and out-of-network services) combined with extended skilled nursing care. One visit is equal to four consecutive hours in a 24-hour period.

The medical plans pay for covered health services for treatment of a disease or injury in the patient's home instead of a hospital or skilled nursing facility. The charge must be made by a home health care agency. Home health care must be prescribed by a physician and supervised by a registered nurse (RN) in the patient's home, and provided by a home health aide or licensed practical nurse (LPN) in the patient's home. Benefits are available only when the home health agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. Skilled home health care is skilled nursing, teaching, and rehabilitation services provided by licensed technical or professional medical personnel to obtain a medical outcome and provide for the patient's safety.

The medical plans cover the following home health care expenses up to the 100-visit limit, combined with extended skilled nursing care, in-network and out-of-network services combined:

- Part-time or occasional care by a licensed nurse
- Intermittent home health aide services
- Services of a medical social worker
- Physical, occupational, speech, and inhalation therapy
- Eligible medical supplies prescribed by a physician
- Services of a nutritionist

Note: For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home, refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information and pre-service authorization requirements and instructions.

Not covered

- Services provided by a home health agency when a primary caregiver could provide those same services in the home. Home health services are not provided as a substitute for a primary caregiver in the home or as a relief (respite) for a primary caregiver in the home.
- Services provided by a primary caregiver in the home.
- Custodial or nonskilled care, maintenance care, or home health care delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair. Custodial or maintenance care includes but is not limited to help getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs. This type of care is primarily required to meet the patient's personal needs or maintain a level of function, as opposed to improving that function to allow for a more independent existence. The care does not require continued administration by trained medical personnel to be delivered safely and effectively.
- Services of a nonmedical nature.
- Services that can be safely and effectively performed by a nonmedical person or self-administered without the direct supervision of a licensed nurse. The unavailability of a person to provide an unskilled service does not allow for coverage for a home health care provider to provide unskilled services.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information.
- Services provided by a family member or a person living in your home.
- Private-duty nursing (see the "Extended skilled nursing care" starting on page 2-73 for more information).

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

If you move during the plan year, resulting in a change in your claims administrator, the 100-visit limit (combined with extended skilled nursing care) per plan year will start over under the new claims administrator.

Homeopathic and naturopathic services

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $25 copay for an office visit with a primary care physician.[2, 3] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay a $25 copay for an office visit with a primary care physician.[2, 3, 4] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit with a primary care physician.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover homeopathic and naturopathic office visits with a state-licensed homeopathic or naturopathic provider.

Note: Homeopathic and naturopathic providers are not licensed in all states; if you receive services from an unlicensed provider, you are responsible for all charges.

Not covered

- Services not considered medically necessary by your claims administrator
- Charges for services received from a non-licensed naturopathic or homeopathic provider or a provider licensed outside of the state where services are rendered

Also, refer to the "Exclusions" section starting on page 2-137.

Hospice care

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

The medical plans cover

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover hospice care that is prescribed by a physician. Hospice care is an integrated program that provides supportive care to terminally ill individuals and their families. This care may be provided instead of a hospital confinement when a covered individual is terminally ill and has less than six months to live. Benefits are available when hospice care is received from a licensed hospice agency for the following services:

- Symptom management
- Inpatient care
- In-home health care services, including nursing care, use of medical equipment, wheelchair and bed rental, and home health aide care
- Physician services
- Respite care (hospice settings only) limited to five consecutive days per episode up to a maximum of 20 days per calendar year, combined in- and out-of-network services
- Emotional support services
- Bereavement counseling for covered family members while the covered person is receiving hospice care

Not covered

- Room and board expenses in a nonapproved residential hospice facility
- Financial or legal counseling services
- Housekeeping or meal services in the patient's home
- Custodial care related to hospice services, whether provided in the home or in a nursing home
- Any service not specifically described as a covered service under hospice services
- Any services provided by a member of the patient's family or resident in the covered person's home

Also, refer to the "Exclusions" section starting on page 2-137.

Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)

Plan	What you pay		
	In-network providers[1]	**Out-of-network providers[1]**	**Out of Area[1, 2] coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. If you need eligible spine (back) and joint (knees and hips) procedures, refer to the "Orthopedic treatment decision support" starting on page 2-44. There is no out-of-network coverage for these services.
2. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers[1]	**Out-of-network providers[1]**	**Out of Area[1, 2] coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

1. If you need eligible spine (back) and joint (knees and hips) procedures, refer to the "Orthopedic treatment decision support" starting on page 2-44. There is no out-of-network coverage for these services.
2. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers*	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

* If you need eligible spine (back) and joint (knees and hips) procedures, refer to the "Orthopedic treatment decision support" starting on page 2-44. There is no out-of-network coverage for these services.

Plan	What you pay		
	In-network providers*	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

* If you need eligible spine (back) and joint (knees and hips) procedures, refer to the "Orthopedic treatment decision support" starting on page 2-44. There is no out-of-network coverage for these services.

The medical plans cover

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover the following types of inpatient hospital services:

- Anesthesia
- Blood and blood derivatives (unless donated or replaced), including charges for presurgical self-blood donations
- Care received for medical stabilization in connection with inpatient services
- Drugs and anesthetics and their administration
- General nursing care
- Intensive care and intensive cardiac care facilities
- Laboratory and diagnostic imaging services
- Miscellaneous medically appropriate hospital services and supplies, including operating room, except as noted under the "Not covered" section on the next page
- Newborn nursery facilities
- Other diagnostic or treatment-related hospital services
- Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level
- Physician and other professional medical and surgical services during an inpatient hospital stay
- Prescription drugs or other medications administered during treatment
- Residential treatment or structured outpatient care (which are considered forms of inpatient care)
- Semiprivate room and board
- Use of operating rooms
- Christian Science services when provided by a Christian Science practitioner or Christian Science nurse for charges while confined for healing purposes in a Christian Science sanatorium for a condition that would require a person of another faith to enter an acute care hospital

Not covered

- Admission for diagnostic tests that can be performed on an outpatient basis
- Comfort or convenience items such as television, telephone, beauty or barber service, or guest service
- Inpatient care that occurs after your coverage terminates, except where a claims administrator's agreement with the provider covers the entire inpatient facility stay
- Late charges for less than a full day of hospital confinement, if for patient convenience
- Private-duty nursing
- Private room charges when facility has a semiprivate room available
- Telephone toll billings for Christian Science services

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

UnitedHealthcare:

Physician and surgeon services received during the inpatient hospital stay:

- If you use an in-network or out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.
- Where assistant surgeon services are appropriate, UnitedHealthcare will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.
- Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

When more than one diagnostic procedure is performed within the same diagnostic family (for example, scopic procedures, x-rays, CT, or MRI) during the same session, one procedure will be considered at 100% of the eligible expense and the other procedures will be considered at 50% of the eligible expense.

Orthopedic Treatment Decision Support

If you complete Orthopedic Treatment Decision Support ("Treatment Decision Support" or "TDS") and use a designated facility for eligible spine (back) and joint (knees and hips) inpatient surgery, the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an in-network provider that is not a designated facility or you have not completed TDS (even if you use an in-network provider or a designated facility), the plan pays 80% of eligible expenses after you satisfy the annual deductible. **No coverage for services received from out-of-network providers.**

Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant's spine (back) and joint (knees and hips) inpatient surgery.

Anthem BCBS:

When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Where assistant surgeon services are appropriate, Anthem BCBS reduces the allowed amount based on the type of assistant surgeon assisting in the surgery.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Orthopedic Treatment Decision Support

If you complete Orthopedic Treatment Decision Support ("Treatment Decision Support" or "TDS") and use a designated facility for eligible spine (back) and joint (knees and hips) inpatient surgery, the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an in-network provider that is not a designated facility or you have not completed TDS (even if you use an in-network provider or a designated facility), the plan pays 80% of eligible expenses after you satisfy the annual deductible. **There is no coverage for services received from out-of-network providers.**

If you are enrolled in a Narrow Network plan, Blue Distinction Centers provisions do not apply, but you do need to receive services from an Anthem Blue High Performance Network facility and provider within the narrow network associated with your plan. If you complete Orthopedic Treatment Decision Support ("Treatment Decision Support" or "TDS") and use an Anthem Blue High Performance Network facility and provider for eligible spine (back) and joint (knees and hips) inpatient surgery, the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an Anthem Blue High Performance Network facility and provider and you have not completed TDS , the plan pays 80% of eligible expenses after you satisfy the annual deductible. There is no coverage for services received from out-of-network providers or an out-of-network facility.

Contact your claims administrator to see if this program is right for you before your surgery. Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant's spine (back) and joint (knees and hips) inpatient surgery.

Aetna:

When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Where assistant surgeon services are appropriate, Aetna will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Orthopedic Treatment Decision Support

If you complete Orthopedic Treatment Decision Support ("Treatment Decision Support" or "TDS") and use a designated facility for eligible spine (back) and joint (knees and hips) inpatient surgery, the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an in-network provider that is not a designated facility or you have not completed TDS (even if you use an in-network provider or a designated facility), the plan pays 80% of eligible expenses after you satisfy the annual deductible. **No coverage for services received from out-of-network providers.**

Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant's spine (back) and joint (knees and hips) inpatient surgery.

Fertility solutions (including services for infertility)

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay: • $25 copay for an office visit with a primary care physician[2, 3] • $45 copay for an office visit with a specialist[2, 3] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Services and treatment for fertility solutions are limited to a lifetime maximum benefit of $25,000. (There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of- network combined; see the "Prescription drug benefit" section starting on page 2-146 for more information on prescription drugs.)	Not covered.	You pay: • $25 copay for an office visit with a primary care physician[2, 3, 4] • $45 copay for an office visit with a specialist[2, 3, 4] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Services and treatment for fertility solutions are limited to a lifetime maximum benefit of $25,000 for in-network and out-of-network medical services combined. (There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined; see the "Prescription drug benefit" section starting on page 2-146 for more information on prescription drugs.)

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance or copay will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible. Services and treatment for fertility solutions are limited to a lifetime maximum benefit of $25,000. (There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined; see the "Prescription drug benefit" section starting on page 2-146 for more information on prescription drugs.)	Not covered.	You pay 20% of eligible covered expenses after you satisfy the deductible. Services and treatment for fertility solutions are limited to a lifetime maximum benefit of $25,000 for in-network and out-of-network medical services combined. (There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined; see the "Prescription drug benefit" section starting on page 2-146 for more information on prescription drugs.)

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible. Services and treatment for fertility solutions are limited to a lifetime maximum benefit of $25,000. (There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined; see the "Prescription drug benefit" section starting on page 2-146 for more information on prescription drugs.)	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit with a primary care physician.[1, 2] • $45 copay for an office visit with a specialist.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge. Services and treatment for fertility solutions are limited to a lifetime maximum benefit of $25,000. (There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined; see the "Prescription drug benefit" section starting on page 2-146 for more information on prescription drugs.)	No coverage.	No coverage.

1. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance or copay will apply to eligible expenses for covered health services.
2. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

The medical plans cover

Pre-service authorization is required for all fertility solutions services and treatments (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). Members must use a designated network of providers for certain fertility solutions services. Note that a provider is not necessarily considered a designated provider just because it is an in-network provider. Contact your claims administrator for more information prior to beginning any services or treatments covered by this fertility solutions section. Fertility solutions benefits are limited to a lifetime maximum benefit paid by the medical plan of $25,000 (in-network and out-of-network medical services combined; services from an out-of-network provider are only covered for individuals with Out of Area coverage, refer to the "Fertility solutions (including services for infertility)" cost sharing tables starting on page 2-87 for more information on Out of Area coverage). There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined (see the "Prescription drug benefit" section starting on page 2-146 for more information on prescription drugs). Fertility solutions benefits are in addition to/separate from those covered in the "Women's preventive health care services" section starting on page 2-135.

Fertility solutions benefits listed below are provided only to a covered employee or dependent, not to a surrogate:

- Artificial insemination (AI).
- Intrauterine insemination.
- *In vitro* fertilization (fresh IVF cycle).
- Embryo adoption preparation and transfer.
- Frozen embryo transfer (FET) cycle, including the associated cryopreservation and storage of embryos. Long-term storage costs (anything longer than 12 months) are the responsibility of the member.
- Gamete intrafallopian transfer (GIFT).
- Zygote intrafallopian tube transfer (ZIFT).
- Intracytoplasmic sperm injection (ICSI).
- Ovulation induction and controlled ovarian stimulation.
- Preimplantation genetic diagnosis (PGD) is covered for the diagnosis of known genetic disorders only (for example, cystic fibrosis).
- Preimplantation genetic screening (PGS).
- Testicular sperm aspiration (TESA).
- Microsurgical epididymal sperm aspiration (MESA).
- Electroejaculation (EEJ).
- Surgical procedures:
  - Laparoscopy
  - Lysis of adhesions
  - Tubotubal anastomosis following a nonvoluntary sterilization
  - Fimbrioplasty
  - Salpingostomy
  - Transcervical catheterization
  - Strassman metroplasty
- Donor coverage. The plan will cover associated donor medical expenses only when the donor is a covered member (of a self-insured option of the Wells Fargo Health Plan), including preparation of oocyte or sperm. A covered female member's ovary stimulation and retrieval of eggs are covered when a member is using a surrogate (host uterus). The implantation of eggs, oocytes, embryo, or donor sperm into a host uterus is not covered. Male member retrieval of sperm is covered. The plan will not pay for donor charges associated with compensation or administrative services.
- Fertility preservation. The plan will cover fertility preservation for a covered member when diagnosis of cancer is present and treatment is likely to produce infertility or sterility. Coverage is limited to collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of eggs, oocyte cryopreservation, ovarian tissue cryopreservation, *in vitro* fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are the responsibility of the member.
- Infertility treatment following the successful reversal of voluntary sterilization (tubal reversal/reanastomosis, vasectomy reversal/vasovasostomy or vasoepididymostomy).

As new services and treatments become available, they will be considered for coverage based on the claims administrator's policy guidelines.

Not covered

- Charges related to a surrogate or gestational carrier on your behalf, including any donor, insemination, transfer, or implantation processes.
- Reversal of voluntary sterilization and any related charges
- Treatment of infertility/fertility after unsuccessful reversal of sterilization and any related charges
- Fees or payment associated with embryo adoption
- Fees or payment to a donor associated with compensation or administrative services for sperm or oocyte donations
- Fees for maintenance or storage of sperm or oocyte, except as otherwise noted
- Fees for maintenance or storage of frozen embryos beyond 12 months
- Medications for anyone not enrolled in the plan, including a donor or surrogate
- Services and prescription drugs for or related to gender selection services
- Services exceeding the lifetime maximum for this benefit
- Social cryopreservation to delay pregnancy for nonmedical reasons or when a diagnosis of cancer is not present

- Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation)

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

Refer to the "Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery" starting on page 2-132 for information about covered travel expenses related to infertility and fertility services and treatment.

Maternity care

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	See the "Notes" section starting on page 2-93.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	See the "Notes" section starting on page 2-93.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	See the "Notes" section starting on page 2-93.	You pay 50% of eligible covered expenses after you satisfy the deductible.	See the "Notes" section starting on page 2-93.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	See the "Notes" section starting on page 2-93.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	See the "Notes" section starting on page 2-93.	No coverage.	No coverage.

The medical plans cover

The medical plans cover all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The medical plans will pay benefits for the covered mother and the newborn (provided that you add the child to your medical coverage through Wells Fargo within 60 days of the date of birth; refer to "Chapter 1: Eligibility, Enrollment, and More") for an inpatient stay while both are in the hospital, as follows:

- 48 hours from time of delivery for the mother and newborn child following a normal delivery
- 96 hours from time of delivery for the mother and newborn child following a cesarean section delivery

You do not need authorization from the claims administrator if your provider prescribes a hospital stay of this length. However, if your provider determines that a longer stay is required for either the mother or the baby, you must notify your claims administrator as soon as reasonably possible. If you don't notify the claims administrator that the inpatient stay will be extended, benefits for the extended stay may be reduced.

If the mother agrees, the attending provider may discharge the mother, the newborn child, or both, earlier than these minimum stays.

Refer to the "Preventive care services (eligible preventive care services)" section starting on page 2-114 for information on newborn immunization and routine prenatal care. See the "Enrolling a newborn or newly adopted child" section in "Chapter 1: Eligibility, Enrollment, and More" for information about how to add your child to your medical plan coverage.

You must add your child within 60 days of the date of birth to receive benefits for any charges incurred by the newborn.

For women's preventive health care services, see the "Women's preventive health care services" section starting on page 2-135.

Not covered

- Adoption
- Childbirth classes
- Preparation to be a surrogate or gestational carrier including any donor, insemination, implantation, or transfer processes

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

For services received from an in-network provider or if you have Out of Area coverage, what you pay depends on the plan in which you are enrolled and how your provider bills for the services received as described below under "*Initial visit to diagnose pregnancy*," "*Global bill*," and "*Charges billed separately (not a global bill)*."

Initial visit to diagnose pregnancy:

- **Copay Plan with HRA (in-network and Out of Area coverage only) and Narrow Network Copay Plan**

  You will pay a $25 copay (no deductible) for the initial office visit to a PCP or OB/GYN, if the charge is coded as an office visit. Any associated charges, such as lab work, are subject to the annual deductible and coinsurance.

- **Higher Use Plan with HSA, Lower Use Plan with HSA, or Flex HDHP (in-network and Out of Area coverage only) and Narrow Network Plan with HSA**

  You will pay 20% coinsurance after the annual deductible has been met.

Global bill:

After pregnancy has been confirmed, for additional maternity-related services, your provider may submit a global bill to the claims administrator that includes physician services for routine prenatal and postnatal care, and the physician's charges for delivery. A global bill is generally submitted postpartum.

- The applicable annual deductible applies to the global bill charge; you are required to meet the annual deductible.
- After the annual deductible is met, you will pay 20% coinsurance for the global bill.

Some services may be nonroutine or not part of the global bill, such as but not limited to labs, ultrasounds, services provided by a specialist, and hospital charges; you will pay the applicable copay or deductible and coinsurance for these services depending on how they are billed.

Charges billed separately (not a global bill):

After pregnancy has been confirmed, if your provider does not submit a global bill (and is not required to), all additional services will be billed and processed separately. You will pay the applicable copay or deductible and coinsurance for these services depending on how they are billed.

Other important information:

The following applies regardless of whether you receive **services from an in-network or out-of-network provider**:

- If you are enrolled in the Copay Plan with HRA, you may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.
- Hospital inpatient services are subject to the applicable annual deductible and coinsurance. See the ""Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)" section starting on page 2-84 for more information.
- Some prenatal and postnatal care is considered eligible preventive care. See the "Preventive care services (eligible preventive care services)" section starting on page 2-114 for coverage of these services.
- Separate copays apply for any prescriptions (see the "Prescription drug benefit" section starting on page 2-146 for more information).
- Be aware that your in-network provider may enlist the services of an out-of-network provider and those services may be billed separately and will be subject to the out-of-network annual deductible and cost-sharing.
- When you receive services from an out-of-network provider, in addition to the applicable annual deductible and coinsurance, you also pay the amount above the allowed amount and all expenses not covered by the plan. The amounts above the allowed amount and expenses not covered by the plan do not count toward the annual deductible or the annual out-of-pocket maximum.
  - **There is no out-of-network coverage under the Narrow Network Copay Plan or Narrow Network Plan with HSA.** You are responsible for 100% of the charges for services received from out-of-network providers and those amounts do not count toward the annual deductible or annual out-of-pocket maximum.

UnitedHealthcare:

In-home midwives, birthing centers, and fetal monitors (including intrauterine devices) are covered. Certified midwives are covered on an in-network basis regardless of the provider's network status.

Anthem BCBS:

Anthem BCBS covers one home health care visit within four days of discharge from the hospital if either the mother or the newborn child is confined for a period less than the 48 hours for normal delivery or 96 hours for cesarean delivery, as mentioned above. See the "Home health care" section starting on page 2-78.

Aetna:

In-home midwives and birthing centers are covered. Under certain criteria, fetal monitors (including intrauterine devices) may be covered. Certified midwives are covered on an in-network basis regardless of the provider's network status.

Mental health and substance abuse residential treatment

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

The medical plans cover

Residential treatment is considered inpatient hospital care. Pre-service authorization is required for all inpatient hospital care (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). **However, it is strongly recommended that you call the applicable claims administrator before receiving any related services to ensure that the services you seek are covered under the plan.** In addition, you can get information about in-network providers available in your area. If pre-service authorization is received, the medical plans cover mental health and substance abuse licensed residential treatment services that are provided in a facility or a freestanding residential treatment center that provides overnight mental health services or substance abuse treatment for individuals who do not require acute inpatient care but who do need 24-hour medical supervision.

To be covered, the claims administrator's residential treatment criteria must be met and the center must include an adequate educational program as determined by the applicable claims administrator at its discretion.

A residential treatment facility is a facility that provides a program of effective mental health services substance use disorder services treatment and that meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator.
- It has or maintains a written, specific, and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board
  - Evaluation and diagnosis
  - Counseling
  - Referral and orientation to specialized community resources

A residential treatment facility that qualifies as a hospital is considered a hospital.

Admission to a residential treatment center is not intended for use as a long-term solution or to maintain the stabilization acquired during treatment in a residential facility or program.

Not covered

- Halfway houses, extended care facilities or comparable facilities, foster care, adult foster care, and family child care provided or arranged by the local, state, or county agency
- Services that do not meet the claims administrator's coverage criteria
- Educational services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to, boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility, or residential treatment center. This exclusion includes procedures, equipment, services, supplies, or charges for the following:
  - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - Services or care provided or billed by a school, custodial care center for the developmentally disabled, wilderness or outdoor camps and programs, even if psychotherapy is included.

Also, refer to the "Exclusions" section starting on page 2-137.

Nutritional formulas

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

The medical plans cover

The medical plans cover certain nutritional formulas only when:

- Used as the definitive treatment of an inborn metabolic disorder, such as phenylketonuria (PKU), or conditions that interfere with nutrient absorption and assimilation, such as eosinophilic enteritis, as deemed medically appropriate and necessary based on the claims administrator's medical policy
- Used as the sole source of nutrition by enteral feedings, as deemed medically appropriate and necessary based on the claims administrator's medical policy

The medical plans also cover total parenteral nutrition and intravenous (TPN/IV) therapy, equipment, supplies, and drugs in connection with IV therapy. IV line care kits are covered as durable medical equipment. See the "Durable medical equipment, supplies, and prosthetics" section starting on page 2-69.

Not covered

- Enteral feedings and nutritional formulas, including infant formula (except as previously noted)
- Electrolyte supplements, nutritional supplements, and dietary supplements
- Donor breast milk
- Diets for weight control or treatment of obesity (including liquid diets or food)
- Food, food substitutes, meal replacements, or food supplements of any kind (such as diabetic, low-fat, low-cholesterol, or infant formula)
- Over-the-counter oral vitamins and oral minerals
- Megavitamin and nutrition-based therapy
- Oral vitamins and oral minerals

Also, refer to the "Exclusions" section starting on page 2-137.

Nutritionists

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $25 copay for an office visit with a primary care physician.[2, 3] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay a $25 copay for an office visit with a primary care physician.[2, 3, 4] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit with a primary care physician.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover nutritional counseling provided in a physician's office by an appropriately licensed nutritionist or health care professional when education is required for a disease in which patient self-management is an important component of treatment and when a knowledge deficit exists regarding the disease for which the intervention of a trained health professional is required. Some examples of such medical conditions include:

- Congestive heart failure
- Coronary artery disease
- Diabetes
- Gout
- High cholesterol
- Phenylketonuria (PKU)
- Renal failure
- Severe obstructive airway disease

Not covered

Nutritional counseling for either individuals or groups (except as stated above), including weight loss programs, health clubs, and spa programs.

Also, refer to the "Exclusions" section starting on page 2-137.

Office visit — primary care physician (PCP) (in-person or virtual)

Note: Physicians who qualify as PCPs are listed below.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $25 copayment for an office visit with a primary care physician.[2, 3] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay a $25 copay for an office visit with a primary care physician.[2, 3, 4] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit with a primary care physician.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover regular office visits with an eligible primary care physician (PCP), which includes:

- Family Medicine physicians
- General Practice physicians
- Internal Medicine physicians
- Nurse Practitioners
- Obstetricians and Gynecologists
- Pediatricians
- Physician Assistants

Although not typically thought of as primary care physicians, the $25 copay for an office visit with a primary care physician also applies to office visits with the following providers (for coverage details of the corresponding services, see the applicable sections in this chapter):

- Acupuncturist
- Chiropractor
- Homeopath or Naturopath
- Nutritionist
- Midwife (Certified Nurse)
- Occupational Therapist
- Physical Therapist
- Speech Therapist

The copay, if applicable, only applies to the eligible expense for the PCP office visit charge. It does not apply to services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by a specialist brought in to the PCP office visit to examine, diagnose, or provide you with treatment, even if these additional services are performed within the examination room or the provider's facility. If you receive any services and supplies during your office visit, those services and supplies may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services. Refer to the "Outpatient surgery, diagnostic, and therapeutic services" section starting on page 2-107 for more information about what you will pay.

Notes

- An eye exam for individuals diagnosed with diabetes is covered at coinsurance, no deductible.
- For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home, refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information, pre-service authorization requirements and instructions, and how to order and ship specialty medications from the Accredo Specialty Pharmacy to the physician's office.

Not covered

- Services from a physician or provider who is not listed as an eligible primary care physician in the previous column are not covered under this provision.
- Services of a Christian Science practitioner or a Christian Science nurse, except as listed in the "Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)" section starting on page 2-84.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information.

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

For obstetrical and gynecological office visits related to pregnancy or maternity care, see the "Maternity care" section starting on page 2-92.

Office visit — non-primary care physician or specialist (in-person or virtual)

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $45 copay for an office visit with a specialist.[2, 3] For services billed separately from a specialist office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay a $45 copay for an office visit with a specialist.[2, 3, 4] For services billed separately from a specialist office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought in to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance or copay will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $45 copay for an office visit with a specialist.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from a specialist office visit charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought in to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the specialist's facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover regular office visits with a specialist or other physician or provider who is not defined as an eligible primary care physician (see the "Office visit — primary care physician (PCP) (in-person or virtual)" section starting on page 2-100 for a listing of the types of providers who are considered eligible primary care physicians). Some services may require pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-45).

The copay, if applicable, only applies to the eligible expense for the office visit charge. It does not apply to services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by a specialist brought in to the office visit to examine, diagnose, or provide you with treatment, even if these additional services are performed within the examination room or the provider's facility. If you receive any services and supplies during your office visit, those services and supplies may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services. Refer to the "Outpatient surgery, diagnostic, and therapeutic services" section starting on page 2-107 for more information about what you will pay.

Notes

- An eye exam for individuals diagnosed with diabetes is covered at coinsurance no deductible.
- For prescription drugs that require administration under the direct supervision of a health care professional, refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information, pre-service authorization requirements and instructions, and how to order and ship specialty medications from the Accredo Specialty Pharmacy to the physician's office.

Not covered

- Services of a Christian Science practitioner or a Christian Science nurse, except as listed in the "Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)" section starting on page 2-84.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information.

Also, refer to the "Exclusions" section starting on page 2-137.

Outpatient mental health and substance abuse office visits and other services (in-person or virtual)

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $25 copay for an office visit.[2, 3] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay a $25 copay for an office visit.[2, 3, 4] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover outpatient office visits (including couples counseling) for professional mental health and substance abuse services for evaluation, crisis intervention, and treatment of mental and nervous disorders as described in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or other professionally recognized reference publication acceptable to the claims administrator.

Note: Residential treatment, structured outpatient care, intensive outpatient therapy, and partial hospitalizations are not covered under the outpatient services benefit. These services are considered inpatient care (see the "Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)" section starting on page 2-84).

Applied behavioral analysis (ABA) services are not covered under these "Outpatient mental health and substance abuse office visits and other services" benefits. All services related to ABA are considered under the "Autism coverage" section starting on page 2-58.

Covered health services and supplies are based on the coverage criteria or medical policy of the claims administrator. Contact the claims administrator for information.

The copay, if applicable for outpatient mental health or substance abuse office visits, only applies to the eligible expense for the office visit charge. It does not apply to services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or other testing procedures), or services performed by a specialist brought in to the office visit to examine, diagnose, or provide you with treatment, even if these additional services are performed within the examination room, office, or the provider's facility. If you receive any services and supplies during your office visit, those services and supplies may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services. Refer to the "Outpatient surgery, diagnostic, and therapeutic services" section starting on page 2-107 and the "Psychological and neuropsychological testing" section starting on page 2-117 for more information.

Not covered

Refer to the "Exclusions" section starting on page 2-137.

Outpatient surgery, diagnostic, and therapeutic services

Plan	What you pay		
	In-network providers[1]	**Out-of-network providers[1]**	**Out of Area[1, 2] coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. If you are billed for an associated office visit, you will pay: • $25 copay for an office visit with a primary care physician[3, 4] • $45 copay for an office visit with a specialist[3, 4] You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. If you are billed for an associated office visit, you will pay: • $25 copay for an office visit with a primary care physician[3, 4, 5] • $45 copay for an office visit with a specialist[3, 4, 5] You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. If you need eligible spine (back) and joint (knees and hips) procedures, refer to the "Orthopedic treatment decision support" starting on page 2-44.
2. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
3. The deductible does not apply.
4. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance or copay will apply to eligible expenses for covered health services.
5. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers[1]	**Out-of-network providers[1]**	**Out of Area[1, 2] coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

1. If you need eligible spine (back) and joint (knees and hips) procedures, refer to the "Orthopedic treatment decision support" starting on page 2-44.
2. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers[1]	Out-of-network providers	Out of Area coverage
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible. If you are billed for an associated office visit, you will also pay: • $25 copay for an office visit with a primary care physician.[2, 3] • $45 copay for an office visit with a specialist.[2, 3]	No coverage.	No coverage.

1. If you need eligible spine(back) and joint (knees and hips) procedures, refer to the "Orthopedic treatment decision support" starting on page 2-44.

2. The deductible does not apply.

3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance or copay will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover outpatient surgery, diagnostic, and therapeutic services received on an outpatient basis in a physician's office, at a clinic, and at a hospital or alternate facility including:

- Diabetes outpatient self-management training and education, including medical nutrition therapy.
- Scheduled surgery, anesthesia, and related services.
- Scopic procedures — outpatient diagnostic and therapeutic.
  - Diagnostic scopic procedures are those for visualization, biopsy, and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.
  - Benefits do not include inpatient surgical scopic procedures. Benefits for inpatient surgical scopic procedures are covered in the "Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)" section starting on page 2-84.
- Radiation and chemotherapy.
- Kidney dialysis (both hemodialysis and peritoneal dialysis).
- Lab.
- X-ray.
- Medical education services include medical education services that are provided on an outpatient basis by appropriately licensed or registered health care professionals when education is required for a disease in which patient self-management is an important component of treatment, and where a knowledge deficit exists regarding the disease for which the intervention of a trained health professional is required.

For women's preventive health care services, see the "Women's preventive health care services" section starting on page 2-135.

Not covered

- Surgery that is intended to allow you to see better without glasses or other vision correction, including radial keratotomy, laser, and other refractive eye surgery.
- Prescription drugs that do not require administration under the direct supervision of a health care professional. The prescription drug benefit is administered by Express Scripts. Refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information.

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

UnitedHealthcare:

You or your provider must contact UnitedHealthcare for pre-service authorization before you receive the following services:

- CT or CAT scans (computer-aided tomography)
- Dialysis
- Imaging cardiac stress tests
- MRI scans (magnetic resonance imaging)
- Mammography testing
- PET scans, MRI, MRA, nuclear medicine, and major diagnostic services
- Prescription drugs that require administration under the direct supervision of a health care professional

If you use an in-network or an out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.

Where assistant surgeon services are appropriate, UnitedHealthcare will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

When more than one diagnostic procedure is performed within the same diagnostic family (for example, scopic procedures, x-rays, CT, and MRI) during the same session, one procedure will be considered at 100% of the eligible expense and the other procedures will be considered at 50% of the eligible expense.

Anthem BCBS:

You must contact Anthem BCBS for pre-service authorization before you receive the following services:

- CT or CAT scans (computer-aided tomography)
- Imaging cardiac stress tests
- MRI scans (magnetic resonance imaging)
- Mammography testing
- PET, MRI, and MRA scans, nuclear medicine, and major diagnostic services (in-network physicians are required to get a high-tech radiology notification)

When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Where assistant surgeon services are appropriate, Anthem BCBS reduces the allowed amount based on the type of assistant surgeon assisting in the surgery.

Aetna:

When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Where assistant surgeon services are appropriate, Aetna reduces the allowed amount based on the type of assistant surgeon assisting in the surgery.

If you complete Orthopedic Treatment Decision Support ("Treatment Decision Support" or "TDS") and use a designated facility for eligible spine (back) and joint (knees and hips) outpatient surgery, the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an in-network provider that is not a designated facility or you have not completed TDS (even if you use an in-network provider or a designated facility), the plan pays 80% of eligible expenses after you satisfy the annual deductible. No coverage for services received from out-of-network providers.

Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant's spine (back) and joint (knees and hips) outpatient surgery.

Palliative care

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay: • $25 copay for an office visit with a primary care physician[2, 3] • $45 copay for an office visit with a specialist[2, 3] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay: • $25 copay for an office visit with a primary care physician[2, 3, 4] • $45 copay for an office visit with a specialist[2, 3, 4] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance or copay will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit with a primary care physician.[1, 2] • $45 copay for an office visit with a specialist.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the office visit charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance or copay will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover palliative care. Palliative care includes symptom management, education, and establishing goals for care if you have a medical condition with a prognosis of a life expectancy of two years or less.

Not covered

Refer to the "Exclusions" section starting on page 2-137.

Physician services — inpatient and outpatient facilities (other than an office visit charge)

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

The medical plans cover

- Physician services, which include:
  - Allergy testing, serum, and injections administered by a health care professional that are not self-injectable
  - Inpatient hospital or facility visits
  - Outpatient hospital or facility visits
- Surgery:
  - For UnitedHealthcare, if you use an in-network or an out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense. Where assistant surgeon services are appropriate, UnitedHealthcare will reduce the allowed amount for the assistant surgeon based on the type of assistant surgeon assisting in the surgery.
  - For Aetna and Anthem BCBS, when more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced. Where assistant surgeon services are appropriate, Aetna and Anthem BCBS reduce the allowed amount for the assistant surgeon based on the type of assistant surgeon assisting in the surgery.
  - Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.
  - Anesthesia administered by a provider other than the operating, delivering, or assisting provider is covered.
- Treatment of eye disease
- Diabetes outpatient self-management training and education, including medical nutrition therapy
- Inpatient hospital or facility visits during a covered admission

Note: For prescription drugs that require administration under the direct supervision of a health care professional, refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information, pre-service authorization requirements and instructions, and how to order and ship specialty medications from the Accredo Specialty Pharmacy to the outpatient facility administering the specialty medication.

Not covered

- Charges for a physician who does not perform a service but is on call.
- Routine physical examinations not required for health reasons, including but not limited to employment, insurance, government license, court-ordered, forensic, or custodial evaluations.
- Services of a Christian Science practitioner or nurse.
- Charges for Christian Science care in a Christian Science sanatorium.
- Internet or similar communications for the purpose of scheduling medical appointments, refilling or renewing existing prescription medications, reporting normal medical test results, providing education materials, updating patient information, requesting a referral, and services that would similarly not be charged for an on-site medical office visit.
- Cosmetic surgery or treatment related to the consequences, or as a result, of non-covered cosmetic surgery as determined by the claims administrator.
- Repair of scars and blemishes on skin surfaces.
- Separate charges for pre- and postoperative care for surgery.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the "Prescription drug benefit" section starting on page 2-146 for coverage information.

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

Services coded by your provider as received in an outpatient facility will be subject to the outpatient facility coinsurance (not the office visit coinsurance).

Preventive care services (eligible preventive care services)

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	The medical plan pays 100% of eligible covered expenses.	You pay 50% of eligible covered expenses (you are not required to meet the annual deductible before eligible preventive care services are covered). You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	The medical plan pays 100% of eligible covered expenses.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	The medical plan pays 100% of eligible covered expenses.	You pay 50% of eligible covered expenses (you are not required to meet the annual deductible before eligible preventive care services are covered).	The medical plan pays 100% of eligible covered expenses.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	The medical plan pays 100% of eligible covered expenses.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	The medical plan pays 100% of eligible covered expenses.	No coverage.	No coverage.

The medical plans cover

The medical plans cover eligible in-network preventive care services at 100% except as noted in this "Preventive care services (eligible preventive care services)" section.

Note: For in-network services, you do not need to satisfy the deductible. If you use out-of-network providers while enrolled in a Copay Plan with HRA, eligible preventive care services are not subject to the out-of-network deductible, you pay 50% of the eligible covered expense.

For a service to be considered an eligible preventive care service, it must be a preventive care service recommended by one of several federal government or independent agencies responsible for the development and monitoring of various U.S. preventive care guidelines. Many of the guidelines take into account gender, age, and your or your family's medical history.

Preventive care services for children

As recommended under the Bright Futures guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics, the types of services for children covered as preventive care services include but are not limited to:

- Well-baby care physical exams
- Well-child care physical exams
- Vision and hearing screenings
- Developmental assessments
- Screening for depression and obesity
- Obesity counseling
- Preventive eye exam for the following conditions: glaucoma, macular degeneration, and diabetes

Routine vaccines

As recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices, the types of routine vaccines covered as preventive care services include but are not limited to:

- Routine childhood immunizations such as diphtheria, tetanus, pertussis, polio, chicken pox, measles, mumps, rubella, hepatitis A and B, pneumococcal, meningococcal, rotavirus, human papillomavirus, and flu
- Routine vaccinations for adults such as flu, pneumococcal, tetanus, diphtheria, and zoster

Preventive care services for adults

The types of services that are covered as preventive care services for adults include but are not limited to:

- Adult routine physical exams
- Routine screenings such as blood pressure, cholesterol, and diabetes
- Routine screenings such as mammography (including 3D), colonoscopy, pap smear, and PSA test
- Routine gynecological exams
- Bone density tests
- Routine prenatal care and exams
- Screening for depression and obesity
- Obesity counseling
- Preventive eye exam for the following conditions: glaucoma, macular degeneration, and diabetes

When the claim is filed with the claims administrator, the claim information will indicate the type of services you received. If the claim is coded as an eligible preventive care service with a routine diagnosis code, the claim will be paid as a preventive care service.

If you receive eligible preventive care services at the same time you receive other nonpreventive care services, the nonpreventive care services will be subject to the plan cost-sharing, including the deductible and coinsurance. For example, if you see your provider for a recurring medical problem but also receive an eligible preventive care service, the provider may code the claim as a nonpreventive care office visit. However, the services may be filed on separate claims coding: one for the preventive care services and one for the nonpreventive services or treatments.

If the primary purpose of your visit is for preventive care services (such as an annual physical exam) but you also discuss other health problems during the visit (such as a recurring medical problem), your provider may code the claim as an eligible preventive care service or separate claims may be filed for the preventive and nonpreventive services or treatments.

If you have questions about how claims for your office visit, screenings, lab work, tests, or procedures will be coded, talk to your provider about the type of care you receive or are recommended to receive before the claim is filed with the claims administrator. Once the claim is filed, the claim will be processed based on how your provider coded the claim; that is, services coded by your provider as routine services will be processed as routine services.

For additional information on preventive care coverage under your medical plan, visit the claims administrator's website or call the claims administrator's member services department (see the "Contacts" starting on page 2-4). Also see the "Women's preventive health care services" section starting on page 2-135 for more information on women's preventive health care services.

Other preventive care services

For the following preventive care services, you will pay 20% coinsurance no deductible:

- Glucometer
- Hemoglobin A1C testing
- International normalized ratio (INR) testing
- Low-density Lipoprotein (LDL) testing
- Retinopathy screening

With respect to the high-deductible health plans, these preventive care services will be administered consistent with IRS requirements for qualifying high deductible health plans, including but not limited to Notice 2019-45, which may require a specific diagnosis. The Copay Plan with HRA and the Narrow Network Copay Plan may also require a specific diagnosis. UnitedHealthcare covers Hemoglobin A1C testing and LDL testing at 100% with no deductible.

Not covered

- Adult eye exams with the exception of what is noted above
- Services that are not recommended by one of several federal government or independent agencies responsible for the development and monitoring of various U.S. preventive care guidelines
- Although recommended by one of several government or independent agencies responsible for the development and monitoring of U.S. preventive care guidelines, services that do not follow the government or independent agency's age, gender, or family history recommended guidelines
- Services coded by the provider as nonroutine, which may include but are not limited to:
  - Office visits, screenings, lab work, tests, or procedures to diagnose a condition, treat a specific illness, or monitor an existing condition
  - Additional office visits, lab work, tests, or procedures recommended or required as a result of a preventive care visit, lab work, test, or procedure
  - Office visits, screenings, lab work, tests, or procedures if a condition or diagnosis is detected
  - Part of the services received that are coded as nonroutine (for example, office visits, lab work, tests, or procedures)
- Nonroutine exams
- Nonroutine vaccinations and immunizations
- Physical exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the medical plans when:
  - Required solely for purposes of career, education, sports or camp, employment, insurance, marriage, or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type

Also, refer to the "Exclusions" section starting on page 2-137.

Psychological and neuropsychological testing

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses for services (except for an office visit charge), after you satisfy the deductible. If you are billed for an associated office visit, you will pay $25 copay for an office visit.[2, 3] You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You can use your HealthEquity Healthcare Card to pay for eligible covered expenses with available HRA dollars.	You pay 20% of eligible covered expenses for services (except for an office visit charge), after you satisfy the deductible. You can use your HealthEquity Healthcare Card to pay for your copay and other eligible covered expenses with available HRA dollars. If you are billed for an associated office visit, you will pay $25 copay for an office visit.[2, 3, 4] You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible. If you are billed for an associated office visit, you will also pay a $25 copay for an office visit.[1,2]	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

The medical plans cover psychological and neuropsychological testing when conducted for the purpose of diagnosing a mental disorder in the most recent version of the DSM (*Diagnostic and Statistical Manual of Mental Disorders*) or other professionally recognized reference publication acceptable to the claims administrator, or in connection with treatment of such a mental disorder. **It is strongly recommended that you call the applicable claims administrator before receiving services** to ensure that the services you seek are covered under the plan. In addition, you can get information about in-network providers available in your area. See the "Pre-service authorization requirements" section starting on page 2-45 for the contact information.

Not covered

- Testing to diagnose or rule out a learning disorder or disability
- Physical, psychiatric, or psychological exams, testing, or treatments that are otherwise covered under the medical plans when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage, or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type

Also, refer to the "Exclusions" section starting on page 2-137.

Reconstructive surgery

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible. You can use your HealthEquity Healthcare Card to pay for eligible covered expenses with available HRA dollars.	You pay 20% of eligible covered expenses after you satisfy the deductible. You can use your HealthEquity Healthcare Card to pay for eligible covered expenses with available HRA dollars.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

The medical plans cover

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover certain reconstructive procedures. Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part to address the following:

- Prompt repair of accidental injury that occurs while covered under the medical plan
- To improve function of a malformed body part
- To correct a defect caused by infection or disease

The medical plans also cover the cost of postmastectomy reconstructive surgery performed on you or your eligible covered dependents in a manner determined in consultation with the attending physician and patient for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

The plan covers excess skin removal when the medical records document a skin condition causing a functional impairment and the proposed procedure meets the claims administrator's medical policy criteria for that procedure. Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information).

The plan covers penile prosthesis when deemed medically necessary as defined by the claims administrator.

Additional criteria:

- After significant weight loss unrelated to bariatric surgery, in addition to the criteria listed on page 2-119, there must be documentation that a stable weight has been maintained for six months.
- After significant weight loss following bariatric surgery, in addition to meeting the criteria listed above, there must be documentation that a stable weight has been maintained for six months. This often occurs 12 to 18 months after surgery.

Not covered

- Cosmetic procedures, including but not limited to surgery, pharmacological regimens, nutritional procedures or treatments, scar or tattoo removal, or revision procedures, or skin abrasion
- Dentures, regardless of the cause or condition, and any associated services or charges, including bone grafts
- Dental implants and any associated services and charges
- Lipectomy or liposuction is considered cosmetic and not medically necessary when the procedure does not meet the claims administrator's medical criteria for treatment of lymphedema or lipedema
- Removal of excess skin or fat, or both, when the procedure does not meet the claims administrator's medical criteria
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure
- Repair of scars and blemishes on skin surfaces
- Services related to teeth, the root structure of teeth, or supporting bone and tissue, except as described in the "Dental care" section starting on page 2-67
- Treatment of benign gynecomastia (abnormal breast enlargement in males)

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

UnitedHealthcare:

If you use an in-network or out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.

Where assistant surgeon services are appropriate, UnitedHealthcare will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Anthem BCBS and Aetna:

When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Where assistant surgeon services are appropriate, Aetna and Anthem BCBS reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.

Skilled nursing facility

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 100 days per plan year, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 100 days per plan year, in-network and out-of-network services combined.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 100 days per plan year, in-network and out-of-network services combined.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 days per plan year, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 days per plan year, in-network and out-of-network services combined.	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 days per plan year, in-network and out-of-network services combined.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 days per plan year, in-network and out-of-network services combined.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 days per plan year.	No coverage.	No coverage.

The medical plans cover

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover an inpatient stay in a skilled nursing facility or acute inpatient rehabilitation facility. Benefits are limited to 100 days per plan year for skilled nursing, in-network and out-of-network services combined. There are no limits for acute inpatient rehabilitation services that meet the claims administrator's coverage policy criteria and are billed as acute inpatient rehabilitation services.

Benefits are available for:

- Services and supplies received during the inpatient stay
- Room and board in a semiprivate room (a room with two or more beds)

Skilled nursing provides benefits if you are recovering from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation, and facility services that are less than those of a general acute hospital but greater than those available in the home setting.

Benefits are available only when skilled nursing, rehabilitation services, or both, are needed on a daily basis. Benefits are not available when these services are required intermittently (such as physical therapy three times a week).

Not covered

- Custodial, domiciliary, or maintenance care (including administration of internal feeds), even when ordered by a physician. Custodial, domiciliary, or maintenance care includes but is not limited to help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs. It is primarily required to meet the patient's personal needs or maintain a level of function, as opposed to improving that function to allow for a more independent existence.
- Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- Services that do not require continued administration by trained medical personnel to be delivered safely and effectively.
- Treatment, services, or supplies that do not meet the definition of a covered health service.
- Private-duty nursing.

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

If you move during the plan year, resulting in a change in your claims administrator, the 100-day limit per plan year will start over under the new claims administrator.

Telemedicine/Virtual visits (with certain in-network providers)

Plan	What you pay		
	In-network providers[1]	**Out-of-network providers**	**Out of Area[2] coverage**
Copay Plan with HRA	You pay a $10 copay when the claims administrator's telemedicine/virtual visit application is used.[1, 3]	If you consult with a provider online or by phone who is not associated with your claims administrator's telemedicine/virtual visit application, refer to the "Office visit — primary care physician (PCP) (in-person or virtual)" starting on page 2-100, the "Outpatient mental health and substance abuse office visits and other services (in-person or virtual)" starting on page 2-105, or the "Office visit — non-primary care physician or specialist (in-person or virtual)" starting on page 2-103 for coverage and cost-sharing information.	You pay a $10 copay when the claims administrator's telemedicine/virtual visit application is used.[1, 3] No out-of-network coverage.[2]

1. The claims administrator's telemedicine/virtual visit applications are **Aetna**: Teladoc (Teladoc.com/Aetna); **Anthem BCBS**: LiveHealth Online (livehealthonline.com); **UnitedHealthcare**: Amwell, Doctor on Demand, Optum Virtual Care, and Teladoc (accessed through myuhc.com). Behavioral health telemedicine/virtual visit applications are **Aetna**: Teladoc (Teladoc.com/Aetna); **Anthem BCBS**: LiveHealth Online (livehealthonline.com); **UnitedHealthcare**: Amwell, and Doctor on Demand (accessed through myuhc.com). All are subject to change at any time by claims administrator.
2. Because the in-network telemedicine/virtual visits are online or over the phone, there is no coverage for similar services received from an out-of-network provider, even if your home ZIP code is designated outside of the claims administrator's network service area.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies only to the charges for the telemedicine/virtual visit consultation**. The copay does not apply to other services and supplies you may receive in connection with the telemedicine/virtual visit, including but not limited to diagnostic services (for example, lab work) or for any services performed by another physician or specialist who may be brought into the telemedicine/virtual visit to provide further consultation or diagnosis, or recommend treatment, even if those services are performed during the telemedicine/virtual visit. If you receive other services or supplies during the telemedicine/virtual visit, those charges may be billed separately, and eligible expenses are subject to the deductible and applicable coinsurance or additional copay.

Plan	What you pay		
	In-network providers[1]	**Out-of-network providers**	**Out of Area[2] coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.[1]	If you consult with a provider online or by phone who is not associated with your claims administrator's telemedicine/ virtual visit application, refer to the "Office visit — primary care physician (PCP) (in-person or virtual)" starting on page 2-100, the "Outpatient mental health and substance abuse office visits and other services (in-person or virtual)" starting on page 2-105, or the "Office visit — non-primary care physician or specialist (in-person or virtual)" starting on page 2-103 for coverage and cost-sharing information.	You pay 20% of eligible covered expenses after you satisfy the deductible.[1] No out-of-network coverage.[2]

1. The claims administrator's telemedicine/virtual visit applications are **Aetna**: Teladoc (Teladoc.com/Aetna); **Anthem BCBS**: LiveHealth Online (livehealthonline.com); **UnitedHealthcare**: Amwell, Doctor on Demand, Optum Virtual Care, and Teladoc (accessed through myuhc.com). Behavioral health telemedicine/virtual visit applications are **Aetna**: Teladoc (Teladoc.com/Aetna); **Anthem BCBS**: LiveHealth Online (livehealthonline.com); **UnitedHealthcare**: Amwell, and Doctor on Demand (accessed through myuhc.com). All are subject to change at any time by claims administrator.
2. Because the in-network telemedicine/virtual visits are online or over the phone, there is no coverage for similar services received from an out-of-network provider, even if your home ZIP code is designated outside of the claims administrator's network service area.

Plan	What you pay		
	In-network providers[1]	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.[1]	If you consult with a provider online or by phone who is not associated with your claims administrator's telemedicine/ virtual visit application, refer to the "Office visit — primary care physician (PCP) (in-person or virtual)" starting on page 2-100, the "Outpatient mental health and substance abuse office visits and other services (in-person or virtual)" starting on page 2-105, or the "Office visit — non-primary care physician or specialist (in-person or virtual)" starting on page 2-103 for coverage and cost-sharing information.	No coverage.

1. The claims administrator's telemedicine/virtual visit applications are **Aetna**: Teladoc (Teladoc.com/Aetna); **Anthem BCBS**: LiveHealth Online (livehealthonline.com); **UnitedHealthcare**: Amwell, Doctor on Demand, Optum Virtual Care, and Teladoc (accessed through myuhc.com). Behavioral health telemedicine/virtual visit applications are **Aetna**: Teladoc (Teladoc.com/Aetna); **Anthem BCBS**: LiveHealth Online (livehealthonline.com); **UnitedHealthcare**: Amwell, and Doctor on Demand (accessed through myuhc.com). All are subject to change at any time by claims administrator.

Plan	What you pay		
	In-network providers[1]	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay a $10 copay when the claims administrator's telemedicine/virtual visit application is used.[1,2]	If you consult with a provider online or by phone who is not associated with your claims administrator's telemedicine/virtual visit application, refer to the "Office visit — primary care physician (PCP) (in-person or virtual)" starting on page 2-100, the "Outpatient mental health and substance abuse office visits and other services (in-person or virtual)" starting on page 2-105, or the "Office visit — non-primary care physician or specialist (in-person or virtual)" starting on page 2-103 for coverage and cost-sharing information.	No coverage.

1. The claims administrator's telemedicine/virtual visit applications are **Aetna**: Teladoc (Teladoc.com/Aetna); **Anthem BCBS**: LiveHealth Online (livehealthonline.com); **UnitedHealthcare**: Amwell, Doctor on Demand, Optum Virtual Care, and Teladoc (accessed through myuhc.com). Behavioral health telemedicine/virtual visit applications are **Aetna:** Teladoc (Teladoc.com/Aetna); **Anthem BCBS**: LiveHealth Online (livehealthonline.com); **UnitedHealthcare**: Amwell, and Doctor on Demand (accessed through myuhc.com). All are subject to change at any time by claims administrator.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies only to the charges for the telemedicine/virtual visit consultation.** The copay does not apply to other services and supplies you may receive in connection with the telemedicine/virtual visit, including but not limited to diagnostic services (for example, lab work) or for any services performed by another physician or specialist who may be brought into the telemedicine/virtual visit to provide further consultation or diagnosis, or recommend treatment, even if those services are performed during the telemedicine/virtual visit. If you receive other services or supplies during the telemedicine/virtual visit, those charges may be billed separately, and eligible expenses are subject to the deductible and applicable coinsurance or additional copay.

The medical plans cover

The medical plans cover telemedicine/virtual visits, online or by phone, with in-network providers associated with your claim's administrators application as noted below. These applications and associated providers are subject to change at anytime by the claims administrator. It is recommended that you check with your claims administrator before receiving services.

The claims administrator's telemedicine/virtual visits applications are:

- Aetna: Teladoc (Teladoc.com/Aetna)
- Anthem: LiveHealth Online (livehealthonline.com)
- UnitedHealthcare: Amwell, Doctor on Demand, Optum Virtual Care, and Teladoc (accessed through myuhc.com). **Note:** You may be asked to pay up front for your virtual visit with certain providers, but in such cases you will be reimbursed through a claims reimbursement process. Reimbursement will occur automatically.

The claims administrator's behavioral health telemedicine/virtual visit applications are:

- Aetna: Teladoc (Teladoc.com/Aetna)
- Anthem BCBS: LiveHealth Online (livehealthonline.com)
- UnitedHealthcare: Amwell, and Doctor on Demand (accessed through myuhc.com) **Note:** You may be asked to pay up front for your virtual visit with certain providers, but in such cases you will be reimbursed through a claims reimbursement process. Reimbursement will occur automatically.

When using the applications and associated providers, services and supplies over and above the telemedicine/virtual visit consultation may be billed separately, and eligible expenses are subject to the deductible and applicable coinsurance or additional copay. Such services may include but are not limited to recommended diagnostic services (for example, lab work) or for any services performed by another physician or specialist who may be brought into the telemedicine/virtual visit to provide further consultation or diagnosis, or recommend treatment, even if those services are performed during the telemedicine/virtual visit.

If you consult with a provider online or by phone who is not associated with your claims administrator's telemedicine/virtual visit application, refer to the "Office visit — primary care physician (PCP) (in-person or virtual)" starting on page 2-100, the "Outpatient mental health and substance abuse office visits and other services (in-person or virtual)" starting on page 2-105, or the "Office visit — non-primary care physician or specialist (in-person or virtual)" starting on page 2-103 for coverage and cost-sharing information.

Not Covered

- Out-of-network telemedicine/virtual visits
- Refer to the "Exclusions" section starting on page 2-137

Therapy (outpatient physical therapy, occupational therapy, speech therapy, pulmonary therapy, cardiac therapy, and vision therapy)

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $25 copay for an office visit with a primary care physician.[2, 3] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.	You pay a $25 copay for an office visit with a primary care physician.[2, 3, 4] For services billed separately from the office visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information. Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.	You pay 50% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $25 copay for an office visit with a primary care physician[1, 2] • 20% of eligible covered expenses after you meet the deductible for services billed separately from the office visit charge Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the office visit charge.** Certain treatments apply a copay when not billed with an office visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an office visit along with treatment that applies a copay, you will only be responsible for the office visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the office visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the facility. If you receive other services or supplies during your office visit, those charges may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

The medical plans cover

Services may be subject to pre-service authorization requirements (see the "Pre-service authorization requirements" section starting on page 2-45 for more information) and/or assessed for medical necessity based on the claims administrator's medical policy and review guidelines. Generally, the medical plans cover the following types of outpatient therapy services:

- Physical therapy
- Occupational therapy
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

The therapy services must be performed by a licensed therapy provider, under the direction of a physician. Benefits are limited to 90 visits of speech therapy, occupational therapy, and physical therapy combined (the 90-visit maximum is for in-network and out-of-network services combined), per plan year. There are no limitations for pulmonary or cardiac rehabilitation therapy.

Rehabilitation services are only covered to restore previously attained function lost due to injury or illness. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. After an initial evaluation visit, chart notes and an updated treatment plan, including a progress report with measurable objectives and how those objectives have been or will be met, are necessary to validate progress and the need for future visits, whether the provider is an in-network provider or an out-of-network provider.

Habilitative services are covered for congenital, developmental, or medical conditions that have significantly limited the successful initiation of normal speech and normal motor development in children, per the claims administrator's established medical policy.

After an initial evaluation visit, chart notes and an updated treatment plan, including a progress report with measurable objectives and how those objectives have been or will be met, are necessary to validate progress and the need for future visits, whether the provider is an in-network or out-of-network provider.

Vision therapy involves a range of treatment modalities, including lenses, prisms, filters, occlusion, eye exercises, and orthoptics that are used for eye movement and fixation training. The goal of vision therapy is to correct or improve specific visual dysfunctions, such as amblyopia, strabismus, and disorders of accommodation and convergence. Benefit is limited to 20 visits combined for in-network and out-of-network services. Vision therapy is only covered for orthoptic or pleoptic training for diagnosis of amblyopia or exotropia, with continued medical direction and evaluation, up to age 18.

Not covered

- Therapy services that do not meet the claims administrator's criteria guidelines.
- Therapy for voice modulation or similar training (including to teach people to speak another language). Articulation when it's the sole focus of therapy and not related to a neurological motor planning disorder.
- Therapy to improve general physical condition or performance.
- Therapy that has not been approved by the claims administrator.
- Any type of therapy, service, or supply for the treatment of a condition when the therapy, service, or supply ceases to be therapeutic treatment; therapy is excluded if it is administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring, or if objective measurable progress is not being documented.
- Hippotherapy.
- Prolotherapy.
- Eye exercise or vision therapy for those age 18 or older.

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

If you move during the plan year, resulting in a change in your claims administrator, the 90-visit limit (combined therapies) per plan year will start over under the new claims administrator.

Transplant services

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

The medical plans cover

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-45 for more information). If pre-service authorization is received, the medical plans cover organ, bone marrow, and tissue transplants as explained below.

Covered health services and supplies for the following organ or tissue transplants are payable when ordered by a physician. The claims administrator must be notified at least seven working days before the scheduled date of any of the following, or as soon as reasonably possible:

- Evaluation
- Donor search
- Organ procurement or tissue harvest
- Organ transplants

In case of an organ or tissue transplant, donor charges are considered covered health services only if the recipient is a covered person. If the recipient is not a covered person, no benefits are payable for donor charges.

The search for bone marrow or stem cells from a donor who is not biologically related to the patient is not considered a covered health service unless the search is made in connection with a transplant procedure arranged by a designated facility.

If a qualified procedure is a covered health service and performed at a designated facility, the medical care, treatment, transportation, and lodging provisions apply.

Qualified procedures include but are not limited to the procedures listed below. The claims administrator's medical policies determine if a procedure is a qualified procedure.

- Heart
- Heart and lung
- Liver
- Lung (single or double)
- Pancreas for a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session, or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired
- Kidney
- Liver and kidney
- Intestine
- Liver and intestine
- Cornea — you are not required to notify the plan administrator of a cornea transplant, nor is the cornea transplant required to be performed at a designated facility
- Bone marrow and stem cells
- Pancreas
- Kidney and pancreas
- Other transplant procedures when the claims administrator determines that it is medically appropriate to perform the procedure at a designated facility

Medical care and treatment — the covered expenses for services provided in connection with the transplant procedure include:

- Pretransplant evaluation for one of the procedures listed above
- Organ acquisition and procurement
- Hospital and physician fees
- Transplant procedures
- Follow-up care for a period up to one year after the transplant
- Search for bone marrow and stem cells from a donor who is not biologically related to the patient

A designated facility has entered into an agreement with the claims administrator or with an organization contracting on behalf of the medical plans to provide covered health services for the treatment of specified diseases or conditions. A designated facility may or may not be located within your geographic area. To be considered a designated facility, the facility must meet certain standards of excellence and have a proven track record of treating specified conditions as determined by the claims administrator. The fact that a hospital is considered in-network under the medical plan does not mean that it is a designated facility.

Not covered

- Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood-producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary
- Living donor organ or tissue transplants unless otherwise specified in this SPD
- Transportation and lodging expenses not coordinated by the applicable claims administrator
- Expenses in excess of the stated reimbursement or benefit limits
- Nonhuman organ implants or transplants
- Other transplants not specifically listed in this SPD
- Services that would not be performed but for the transplant, even as a result of complications
- Treatment of medical complications that may occur to the donor; donors are not considered covered persons, and are therefore not eligible for the rights afforded to covered persons under this SPD
- Benefits for travel and lodging expenses when you are not using a designated facility

Refer to the "Prescription drug benefit" section starting on page 2-146 for prescription drug coverage information and prescriptions that are not covered.

Also, refer to the "Exclusions" section starting on page 2-137.

Notes

Refer to the "Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery" starting on page 2-132 for information about covered travel expenses related to transplant surgery. Refer to the "Prescription drug benefit" section starting on page 2-146 for prescription drug coverage information and pre-service authorization requirements and instructions.

Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery

The claims administrator will assist the patient and family with travel and lodging arrangements if the patient meets the criteria to receive services and resides more than 50 miles from a:

- Designated facility
- Qualified provider (as determined by the claims administrator) for gender reassignment services (available only under UnitedHealthcare)

Expenses for travel and lodging for the covered person and a companion are available as follows:

- Transportation of the patient and one companion who is traveling on the same days to or from the designated facility (as listed above) for the purposes of an evaluation, an approved surgical procedure, or necessary postdischarge follow-up.
- Reasonable and necessary expenses, as determined by the claims administrator, for lodging for the patient and one companion.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed as determined by the claims administrator.
- Eligible spine (back) and joint (knee and hip) surgery have a $2,000 annual combined maximum transportation and lodging reimbursement limit.

Notes

Anthem BCBS:

Anthem BCBS does not provide a travel and lodging benefit for cancer, congenital heart disease, or gender reassignment services. If you are enrolled in Copay Plan with HRA, Lower Use Plan with HSA, or Higher Use Plan with HSA, you are required to receive bariatric surgery, inpatient lumbar spine, or knee or hip surgery and transplant surgery at a Blue Distinction Center of Excellence or qualified provider, as determined by the claims administrator, to be eligible to receive travel and lodging allowances. Infertility services must be rendered by a Blue Card PPO Provider or qualified provider, as determined by the claims administrator, to be eligible to receive travel and lodging allowances.

If you are enrolled in a Narrow Network Plan, you are required to receive bariatric surgery, inpatient lumbar spine or knee or hip surgery, transplant surgery and infertility treatment at a Blue, High Performance Network or a qualified provider as determined by claims administrator to be eligible to receive travel and lodging allowances.

Aetna:

When significant travel is required to use an Institutes of Excellence facility for transplant or infertility services, the member may be eligible for travel and lodging allowances according to Aetna's standard internal policies and procedures.

When significant travel is required to use an Institutes of Quality facility for bariatric, cardiac, or orthopedic services, the member may be eligible for travel and lodging allowances according to Aetna's standard internal policies and procedures.

If you are enrolled in the Narrow Network Copay Plan or the Narrow Network with HSA Plan, these provisions do not apply.

Urgent Care Clinics

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
Copay Plan with HRA	You pay a $45 copay for an urgent care visit charge.[2, 3] For services billed separately from the urgent care visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay 50% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	You pay a $45 copay for an urgent care visit charge.[2, 3, 4] For services billed separately from the urgent care visit charge, you pay 20% of eligible covered expenses after you satisfy the deductible. You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

1. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to service received from in-network or out-of-network providers.
2. The deductible does not apply.
3. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the urgent care visit charge.** Certain treatments apply a copay when not billed as a visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an urgent care visit along with treatment that applies a copay, you will only be responsible for the urgent care visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your urgent care visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the urgent care visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the urgent care's facility. If you receive other services or supplies during your urgent care visit, those charges may be billed separately from the urgent care visit, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.
4. When you use an out-of-network provider, you are responsible for the copay and for any charges not covered by the plan, including amounts billed by the out-of-network provider that are above the allowed amount (eligible expense).

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the deductible.	You pay 50% of eligible covered expenses after you satisfy the deductible.	You pay 20% of eligible covered expenses after you satisfy the deductible.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to service received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	You pay 20% of eligible covered expenses after you satisfy the deductible.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	You pay: • $45 copay for an urgent care visit charge.[1, 2] • 20% of eligible covered expenses after you satisfy the deductible for services billed separately from the urgent care office charge.	No coverage.	No coverage.

1. The deductible does not apply.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum. **The copay applies to the eligible expense for the urgent care visit charge.** Certain treatments apply a copay when not billed as a visit. If the same provider bills for two or more services that are applicable to copayments rendered on the same day, you will only be responsible for one copayment. If the same provider bills for an urgent care visit along with treatment that applies a copay, you will only be responsible for the urgent care visit copay and will not be charged for that treatment. The copay does not apply to other services and supplies you may receive in connection with your urgent care visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by another physician or specialist brought into the urgent care visit to examine, diagnose, or provide you with treatment, even if those services are performed within the examination room or the urgent care's facility. If you receive other services or supplies during your urgent care visit, those charges may be billed separately from the urgent care visit, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services.

Women's preventive health care services

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
Copay Plan with HRA	The medical plan pays 100% of eligible covered expenses.	You pay 50% of eligible covered expenses (you are not required to meet the annual deductible before eligible preventive care services are covered). You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.	The medical plan pays 100% of eligible covered expenses.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area* coverage**
• **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Flex HDHP**	The medical plan pays 100% of eligible covered expenses.	You pay 50% of eligible covered expenses (you are not required to meet the annual deductible before eligible preventive care services are covered).	The medical plan pays 100% of eligible covered expenses.

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator's network service area and apply to services received from in-network or out-of-network providers.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Plan with HSA	The medical plan pays 100% of eligible covered expenses.	No coverage.	No coverage.

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area coverage**
Narrow Network Copay Plan	The medical plan pays 100% of eligible covered expenses.	No coverage.	No coverage.

The medical plans cover

The medical plans cover eligible women's preventive health services as noted in the table above for women for the following:

- Annual well-woman preventive care visit for an adult woman to obtain recommended preventive services that are age and developmentally appropriate
- Contraceptive methods, including sterilization procedures and patient education and counseling for a woman with reproductive capacity for the following:
  - Diaphragms, cost of diaphragm billed by physician and charge for fitting
  - Implantable and injectable contraceptives, cost of medication billed by physician and injection charges
  - Tubal ligation procedure
  - Intrauterine devices (IUDs), cost of IUD and charge for placement or removal
  - Generic contraceptive prescriptions (see the "Prescription drug benefit" section starting on page 2-146)
- Routine prenatal care
- Screening for gestational diabetes for a woman between 24 and 28 weeks of gestation and at the first prenatal visit for a pregnant woman identified to be high risk for diabetes
- Breast-feeding (lactation) support, supplies, and counseling by a trained provider during pregnancy and during the postpartum period; includes cost of renting breast-feeding equipment
  - For breast-feeding equipment, the plan covers breast pump purchase or rental in conjunction with each birth as long you purchase the pump through your claims administrator's in-network hospital, physician, or durable medical equipment (DME) supplier (under the Copay Plan with HRA Out of Area coverage, Higher Use Plan with HSA Out of Area coverage, Lower Use Plan with HSA Out of Area coverage, and Flex HDHP coverage, you are not required to use an in-network hospital, physician, or durable medical equipment (DME) supplier)
  - For breast-feeding equipment, the plan does not cover any of the following:
    - Breast pumps purchased through any out-of-network hospital, physician, or DME supplier (except as noted above)
    - Items purchased from a retail store
    - Additional supplies, including but not limited to storage containers and freezer packs
- High-risk human papillomavirus DNA testing in a woman with normal cytology results, beginning at age 30, limited to once every three years
- Annual counseling and screening visit for human immune-deficiency virus (HIV) infection for a sexually active woman
- Annual screening and counseling for interpersonal and domestic violence

Note: When the claim is filed with the claims administrator, the claim information will indicate the type of services you received. If the claim is coded as an eligible women's preventive health care service as described above with a routine diagnosis code, the claim will be paid as a women's preventive health care service. Office visit charges billed separately without a preventive diagnosis code are not covered under these provisions (see the "Office visit — primary care physician (PCP) (in-person or virtual)" section starting on page 2-100 and the "Office visit — non-primary care physician or specialist (in-person or virtual)" section starting on page 2-103).

If you receive eligible women's preventive health care services at the same time you receive other nonpreventive care services, the nonpreventive care services will be subject to the plan cost-sharing, including the deductible and coinsurance applicable to the type of service received.

If you have questions about how claims for your office visit, tests, or procedures will be coded, talk to your provider about the type of care you receive or are recommended to receive before the claim is filed with the claims administrator. Once the claim is filed, the claim will be processed based on how your provider coded the claim.

The following may be covered under the Plan but are not considered services covered under women's preventive health care services:

- Services not coded as preventive care services or coded as nonroutine services
- Digital breast tomosynthesis (3D mammography)
- Services not listed above
- Services beyond the frequency limits listed above
- Abortion services
- Over-the-counter items

Also, refer to the "Exclusions" section starting on page 2-137.

Exclusions

In addition to any other exclusions, limitations, or services listed as not covered as specified in this chapter, the medical plans do not cover or pay for the following:

Alternative treatments

Including acupressure, aromatherapy, hypnotism, rolfing, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health except as noted in the "Homeopathic and naturopathic services" starting on page 2-80.

Experimental, investigational, or unproven services

The fact that an experimental or investigational service or an unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition, as determined by the applicable claims administrator.

Experimental or investigational procedure

These include medical, surgical, diagnostic, mental health, substance abuse, wilderness or outdoor therapy (including but not limited to outdoor camps, programs, or the like), or other health care services, technologies, supplies, treatments, therapies, procedures, programs, drug therapies, or devices that, at the time the utilization review organization or the claims administrator makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight, except as otherwise noted in this chapter

Unproven services

These include medical, surgical, diagnostic, mental health, substance abuse, wilderness or outdoor therapy (including but not limited to outdoor camps, programs, or the like) or other health care services, technologies, supplies, treatments, therapies, procedures, programs, drug therapies, or devices where, at the time the utilization review organization or the claims administrator makes a determination regarding coverage in a particular case:

- Reliable, authoritative evidence (as determined by the applicable claims administrator) does not permit conclusions concerning the service's safety, effectiveness, or effect on health outcomes as compared with the standard means of treatment or diagnosis
- The conclusions determine that the treatment, service, or supply is not effective
- Conclusions are not based on trials that meet either of the following designs:
  - Well-conducted, randomized controlled trials in which two or more treatments are compared with each other, and the patient is not allowed to choose which treatment is received
  - Well-conducted cohort studies in which patients who receive study treatment are compared with a group of patients who received standard therapy; the comparison group must be nearly identical to the study treatment group

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research based on well-conducted randomized trials or cohort studies as determined by the applicable claims administrator.

Physical appearance

- Cosmetic procedures
  - Cosmetic procedures are services that change or improve appearance without significantly improving the primary physiological function of the body part on which the procedure was performed, as determined by the claims administrators
  - Cosmetic treatments relating to the consequences of, or as a result of non-covered cosmetic surgery as determined by the claims administrator.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, and flexibility
- Counseling for diversion or general motivation
- Treatment, services, or supplies for unwanted hair growth
- Removal of excess skin or fat, or both, when the procedure does not meet the claims administrator's medical criteria
- Wigs for androgenetic alopecia, which is the most common form of hair loss encompassing conditions such as male pattern baldness or hair thinning

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child, including any service the provider may perform on themself
- Services performed by a provider with your same legal residence
- Charges made by a physician for or in connection with surgery that exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for

the most expensive procedure and one half of the amount otherwise payable for all other surgical procedures

- Services performed by an unlicensed provider or a provider who is operating outside of the scope of his or her license or certification
- Services provided at a diagnostic facility (hospital or free-standing) without a written order from a provider
- Services that are ordered by a provider affiliated with a diagnostic facility (hospital or free-standing) when that provider is not actively involved in your medical care:
  - Before ordering the service
  - After the service is received

This exclusion does not apply to mammography testing.

Services provided under another plan or program

- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements, including but not limited to coverage required by Workers' Compensation, no-fault auto insurance, or similar legislation
- If coverage under Workers' Compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness, or mental illness that would have been covered under Workers' Compensation or similar legislation had that coverage been elected
- Health services for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you
- Charges payable under Medicare
- Charges that the participant is entitled to payment by a public program other than Medicaid

Travel

- Health services provided in a foreign country, unless required as emergency health services
- Travel, transportation, or living expenses, whether or not services are prescribed by a physician
- Travel, transportation, or living expenses, whether or not recommended or prescribed by a physician, except as specified in the "Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery" starting on page 2-132
- Expenses associated with the repatriation of remains

Other exclusions

- Accidents or injuries incurred while self-employed or employed by someone else for wages or profit, including farming
- Additional prescription drug exclusions:
  - Prescription drugs administered in a physician's office, infusion suite, outpatient hospital department, in the home, or other outpatient setting for drugs that do not require administration under the direct supervision of a physician or nurse, excluding in an emergency
  - Over-the-counter drugs and treatments
  - Prescription drugs for outpatient use that are filled by a prescription order or refill
  - Self-injectable medications (this exclusion does not apply to medications that, due to their characteristics, as determined by the claims administrator, must typically be administered or directly supervised by a qualified provider or licensed or certified health professional in an outpatient setting); see the "Prescription drug benefit" section starting on page 2-146 for coverage information
- Any charge for services, supplies, or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency
- Any charges for missed appointments, room or facility reservations, completion of claim forms, or record processing
- Autopsies
- Bone-anchored hearing aids, except as determined by the claims administrator's medical policies
- Braces that straighten or change the shape of a body part, except as noted under durable medical equipment provisions
- Charges for a standby provider or facility when no actual services have been performed
- Charges for or associated with patient advocacy
- Charges for services needed because the patient was engaged in an illegal activity when the injury occurred
- Charges for giving injections that can be self-administered
- Charges for physician services for, or x-ray examinations of, mouth conditions due to periodontal or periapical disease or any condition involving teeth, surrounding tissue or structure, the alveolar process, or the gingival tissue, except for treatment or removal of malignant tumors; this exclusion includes root canal treatment
- Charges for rehabilitation services that would not result in measurable progress relative to established goals, as determined by the applicable claims administrator

- Charges that are eligible, paid, or payable under any medical payment, personal injury protection, automobile, or other coverage (for example, homeowners insurance, boat owners insurance, or liability insurance) that is payable without regard to fault, including charges for services that are applied toward any deductible, copay, or coinsurance requirement of such a policy
- Charges for the purchase or replacement of contact lenses or glasses
- Charges in excess of eligible expenses or in excess of any specified limitation
- Charges made for routine refractions, eye exercises for vision therapy for those age 18 or older, and surgical treatment for correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn
- Charges the provider is required to write off under another plan when the other plan is the primary payer over the Wells Fargo medical plan
- Charges an in-network provider is required to write off
- Child care costs, including day care centers and individual child care
- Claims filed more than 12 months after the date of treatment or services
- Clinical trials, except routine care associated with clinical trials for cancer or another life-threatening disease or condition
- Comfort or convenience items
- Cranial bands, banding, remolding, and helmets (except as noted in the "Durable medical equipment, supplies, and prosthetics" section starting on page 2-69)
- Dental implants and any associated services or charges
- Dentures, regardless of the cause or condition, and any associated services or charges, including bone grafts
- Donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan)
- Durable medical equipment or prosthetic-related devices used specifically as safety items or to affect performance in sports-related activities
- Educational services, except for nutritional counseling as noted under the "Nutritionists" starting on page 2-98
- Enuresis alarms, even if prescribed by a physician
- Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs
- Foot care — hygienic and preventive maintenance foot care
- Foot care — treatment of flat feet
- Foot care — treatment of subluxation of the foot
- Gene therapy, as well as any services, including drugs, procedures, and health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material
- Growth hormone therapy (see the "Prescription drug benefit" section starting on page 2-146 for coverage information)
- Health services and supplies that do not meet the definition of a covered health service (see the "Covered health services definition" section starting on page 2-50 for more information)
- Health services for which you have no legal responsibility to pay or for which a charge would not ordinarily be made in the absence of coverage under the applicable medical plan
- Health services received after the date your coverage under the applicable medical plan ends, including health services for medical conditions arising before the date your coverage under the applicable medical plan ends
- Hippotherapy
- Inpatient hospital room and board expenses that exceed the semiprivate room rate, unless a private room is approved by the claims administrator
- Interest or late fees due to untimely payment for services
- Internet or similar communications for the purpose of scheduling medical appointments, refilling or renewing existing prescription medications, reporting normal medical test results, providing education materials, updating patient information, and requesting a referral, and services that would similarly not be charged for an on-site medical office visit
- Massage therapy unless noted specifically in this SPD
- Medical and surgical treatment and oral appliances for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Newly approved specialty drugs and non-specialty drugs until a thorough review is completed by the claims administrator, at their discretion. This exclusion may not apply if you have a life-threatening sickness or condition (one likely to cause death within one year of the request of treatment) as determined by the claims administrator.
- Nonwearable external defibrillators, even if prescribed by a physician
- Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy
- Pastoral counselors
- Penile implants that are not deemed medically necessary by the claims administrator, including but not limited to sexual dysfunction devices, except as noted specifically in this SPD
- Personal comfort items, such as telephone, television, barber and beauty supplies, and guest services

- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the medical plan when:
  - Required solely for purposes of career, education, sports or camp, employment, insurance, marriage, or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type
- Private-duty nursing (see the "Extended skilled nursing care" section starting on page 2-73 for more information)
- Private room charges when facility has a semiprivate room available
- Prolotherapy
- Psychosurgery
- Repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage, or gross neglect, even if prescribed by a physician
- Replacement of lost or stolen prosthetic devices, even if prescribed by a physician
- Respite care with the exception of hospice care
- Rest cures
- Reversal of voluntary sterilization
- Routine vision screening after age 21
- Services a provider gives to themself or to a close relative (such as a spouse, brother, sister, parent, grandparent, or child)
- Services that do not involve direct patient contact, such as delivery charges and recordkeeping
- Services for hospital confinement primarily for diagnostic studies
- Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood-producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures, except as otherwise indicated in the "Transplant services" section starting on page 2-130
- Services for or related to commercial weight loss programs, fees or dues, nutritional supplements, food, vitamins, and exercise therapy, and all associated labs, physician visits, and services related to such programs
- Services for or related to dental or oral care, treatment, orthodontics, or surgery and any related supplies, anesthesia, or facility charges, except as otherwise indicated in the "Dental care" section starting on page 2-67
- Services for or related to fetal tissue transplantation
- Services for or related to functional capacity evaluations for vocational purposes or determination of disability or pension benefits
- Services for or related to recreational therapy (defined as the prescribed use of recreation and other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, or social disadvantages) or educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including but not limited to health club memberships, aerobic conditioning, therapeutic exercises, massage therapy, and work-hardening programs, and all related material and products for these programs, except as otherwise indicated in the "Women's preventive health care services" section starting on page 2-135 or required by applicable law
- Services for or related to tobacco cessation program fees or related program supplies (see the "Rally Missions" starting on page 2-41, and "Wellness coaching" starting on page 2-40 for information about tobacco cessation programs)
- Services or confinements ordered by a court or law enforcement officer that do not meet the definition of a covered health service, including but not limited to custody evaluation, parenting assessment, education classes for DUI offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs, except as otherwise indicated in the "Women's preventive health care services" section starting on page 2-135 or required by applicable law
- Services performed before the effective date of coverage under the applicable medical plan
- Services received after your coverage under the applicable medical plan terminates, even though your illness started while your coverage was in force (except as otherwise noted in the "Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)" section starting on page 2-84)
- Services for or related to any disease or injury resulting from a war, declared or not, any military duty, or any release of nuclear energy while part of any armed service force of any country; this exclusion does not apply to covered persons who are civilians injured or otherwise affected by war or any act of war or terrorism in a nonwar zone
- Services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants except services related to the implant or removal of an FDA-approved circulatory assist device that supports the heart while the patient waits for a suitable donor heart to become available
- Services that are normally provided without charge, including services of the clergy
- Services that can be provided through a government program for which you as a member of the community are eligible for participation; such programs include but are not limited to school speech and reading programs
- Services prohibited by law or regulation

- Surgical treatment of obesity, excluding morbid obesity
- Transitional living services
- Treatment of excessive sweating (hyperhidrosis)
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Treatment where payment is made by any local, state, or federal government (except Medicaid) or for which payment would be made if the member had applied for such benefits
- Tuition or services that are school-based for children and adolescents
- Ultrasonic nebulizers, even if prescribed by a physician
- Varicose vein treatment of the lower extremities, when it is considered cosmetic; this includes treatment of spider veins and reticular veins
- Vision correction surgery
- Vagus nerve stimulation (VNS) therapy (except for treatments of certain conditions when specific criteria are met as defined in the claims administrator's medical policy)

Claims and appeals

The applicable claims administrator is the named claims and appeals fiduciary for the respective medical plan; each has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the medical plan you are enrolled in.

If you use an in-network provider, the in-network provider generally will obtain necessary pre-service authorizations and will file claims for you. However, you are responsible for following up to ensure that pre-service authorizations are obtained before services are received and that post-service claims are filed within the proper time frame as noted below.

If you receive services from an out-of-network provider, it is your responsibility to receive any required pre-service authorization and correctly file claims on time even if the out-of-network provider offers to assist you with the filing. This means that you need to determine whether your claim is an urgent care (including concurrent care claims), pre-service, or post-service claim. After you determine the type of claim, file the claim as noted below.

The information noted in this "Claims and appeals" section is basic information you need to file a claim. Additional information related to claims filing can be found in "Appendix A: Claims and Appeals."

Urgent care claims (and concurrent care claims)

If your medical plan requires pre-service authorization in order to receive benefits for medical care or treatment and the application of the time periods for making nonurgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, contact the claims administrator. See the "Pre-service authorization requirements" section starting on page 2-45.

Important: Specifically inform the claims administrator that the request is an urgent care claim. Whether a claim is an urgent care claim will be determined by the attending provider, and the claims administrator and the Health Plan will defer to such determination of the attending provider who filed the urgent care claim. Where the attending provider has not determined that the claim is an urgent care claim, the claims administrator will determine if the claim is an urgent care claim.

Claims administrator	Contact
UnitedHealthcare	Phone: 1-800-842-9722
Anthem BCBS	Phone: 1-866-418-7749
Aetna	Phone: 1-877-320-4577

Note: If you need medical care for a condition that could seriously jeopardize your life, you should obtain such care without delay. Benefits will be determined when the claim is processed.

Pre-service claims (pre-service authorization)

If your medical plan requires pre-service authorization to receive benefits for medical care or treatment, contact the claims administrator. See the "Pre-service authorization requirements" section starting on page 2-45.

Claims administrator	Contact	Address
UnitedHealthcare	Phone: 1-800-842-9722	UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130
Anthem BCBS	Phone: 1-866-418-7749	Anthem BCBS UM Services, Inc. PO Box 7101 Indianapolis, IN 46207
Aetna	Phone: 1-877-320-4577	Aetna Claims PO Box 981106 El Paso, TX 79998

Post-service claims

If you receive services from an in-network provider, the in-network provider will file the claim for you as long as you have identified yourself as a participant in the medical plan you are enrolled in. In-network providers are required to file the claim within the time period specified in their contract with the claims administrator, but in no case will a claim be eligible for benefits if filed more than 12 months from the date of service.

If you receive services from an out-of-network provider, you are responsible for ensuring that the claim is filed correctly and on time (within 12 months from date of service), even if the out-of-network provider offers to file the claim on your behalf. The claim forms are available on the applicable claims administrator's website. You may also call the claims administrator's member services department to request a claim form by phone (see the "Contacts" starting on page 2-4). Late filing by an out-of-network provider is not a circumstance allowing for submission beyond the stated 12-month time frame.

When you are responsible for filing the claim, you must complete the appropriate claim form and provide an itemized original bill* from your provider that includes the following:

- Patient name, date of birth, and diagnosis
- Date or dates of service
- Procedure codes and descriptions of services rendered
- Charge for each service rendered
- Service provider's name, address, and tax identification number

* Monthly statements or balance due bills are not acceptable. Generally, photocopies, monthly statements, or balance due bills are only acceptable if you're covered by two plans and sent your primary payer the original bill.

Claims for separate family members should be submitted separately. If another insurance company pays your benefits first, submit a claim to that company first. After you receive your benefit payment from the primary payer, submit your claim for secondary payment to the claims administrator for your medical plan and attach the primary payer's Explanation of Benefits statements along with your claim. It is important for you to keep copies of all submissions; the documentation you submit will not be returned to you.

If you move to a different state or location resulting in a different claims administrator for your medical plan:

- Expenses incurred before the effective date of coverage with the new claims administrator must be filed with the previous claims administrator.
- Expenses incurred after the effective date of coverage with the new claims administrator must be filed with the new claims administrator.

Mailing addresses for post-service claims

Claims administrator	Address
UnitedHealthcare	UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130
Anthem BCBS	Anthem Blue Cross and Blue Shield PO Box 60009 Los Angeles, CA 90060
Aetna	Aetna PO Box 981106 El Paso, TX 79998-1106

Claims payment

After your claim has been processed according to the terms of the plan in which you are enrolled, if you received covered health services from an in-network provider, the in-network level benefit payment (or if applicable, the Out of Area coverage benefit payment) is made to the in-network provider. You are responsible for the applicable in-network (or if applicable, the Out of Area coverage) annual deductible and copay or coinsurance. In addition, you must pay for all charges not covered by the plan. However, you are not responsible for any amounts an in-network provider is required to write off as a result of their contract with the claims administrator.

After your claim has been processed according to the terms of the plan in which you are enrolled, if your plan provides for out-of-network benefits and you received covered health services from an out-of-network provider, the applicable out-of-network (or if applicable, the Out of Area coverage) are paid as noted below:

- *For UnitedHealthcare*, benefits are paid to you and you must pay the out-of-network provider for the full cost of all services received. You may also assign your benefits to the out-of-network provider in writing. If you assign your benefits to the provider for covered health services, the applicable benefit payment will be made to the out-of-network provider instead of you. You are responsible for the applicable out-of-network (or if applicable, the Out of Area coverage) annual deductible and coinsurance or copay. In addition, you must pay the full cost of all charges not covered by the plan.

  Note: An assignment to pay the out-of-network provider generally does not assign any other rights under the Health Plan to that provider, including the right to request plan documents or pursue and appeal an adverse benefit determination on your behalf.

- *For Anthem BCBS*, benefits are paid to you; there is no assignment of benefits except as noted below. You must pay the out-of-network provider for the full cost of all services received.

  Note: If the patient is a dependent whose parents are divorced, the custodial parent may request, in writing, that the applicable out-of-network (or if applicable, the Out of Area coverage) benefit payment be made to the out-of-network provider for covered health services for a child. When the payment is made to the out-of-network provider at the request of the custodial parent, the Health Plan has satisfied its payment obligation. An assignment to pay the out-of-network provider generally does not assign any other rights under the Health Plan to that provider, including the right to request plan documents or pursue and appeal an adverse benefit determination on your behalf.

- *For Aetna*, Aetna will assume that you have provided an Assignment of Benefits (AOB) and will pay any applicable out-of-network (or if applicable, the Out of Area coverage) benefits directly to the out-of-network provider for the services received unless you provide proof to Aetna when you file the claim that you have already paid the provider in full for the charges incurred. In that case, Aetna will issue any applicable benefit payment to you. Whether benefits are paid to you or to the out-of-network provider, you are responsible for the applicable out-of-network (or if applicable, the Out of Area coverage) annual deductible and coinsurance. In addition, you must pay the full cost of all charges not covered by the plan.

  Note: An assignment to pay the out-of-network provider generally does not assign any other rights under the Health Plan to that provider, including the right to request plan documents or pursue and appeal an adverse benefit determination on your behalf.

Claim denials and appeals

If you have a question or concern about a claim, you may call the applicable claims administrator:

- UnitedHealthcare at 1-800-842-9722
- Anthem BCBS at 1-866-418-7749
- Aetna at 1-877-320-4577

In the event your claim is denied (in whole or in part), you may also file a formal appeal under the terms of the Health Plan. Note that if you call the claims administrator, your call will not be considered a formal appeal under the terms of the Health Plan, except if your appeal is identified as an urgent care appeal. A formal written appeal must be filed with the applicable claims administrator within 180 days of the date you receive notification that your claim is denied regardless of any verbal discussions that have occurred regarding your claim.

The appeal process does not, however, apply to any charges a network provider is required to write off as a result of the network provider's contract with the claims administrator or the claims administrator's associated network. The appeals procedures do not apply to requests by health care providers for payments due to them in accordance with contractual arrangements between the provider and the claims administrator or claims administrator's associated network, where the in-network provider has no recourse against you for amounts, in whole or in part, not paid by the Health Plan as directed by the claims administrator. If the patient is not liable for the charges at issue, there is no appeal option under the Health Plan.

Complete information on appeals is provided in "Appendix A: Claims and Appeals."

Right of recovery

The Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, Narrow Network Copay Plan, and the Flex HDHP, as well as the Express Scripts administered prescription drug benefit, are part of the Wells Fargo & Company Health Plan ("Health Plan"). The Health Plan has the right to recover benefits it has paid on your or your dependent's behalf that were: (a) made in error, (b) due to a mistake in fact, (c) paid before you meet the applicable annual deductible, (d) paid before you meet the applicable annual out-of-pocket maximum, (e) caused by the act or omission of another party, (f) covered by no-fault or employers liability laws, (g) available or required to be furnished by or through national or state governments or their agencies, or (h) sustained on the property of a third party. Benefits paid because you, your dependent, or provider misrepresented facts are also subject to recovery. Right of recovery may be pursued by claims reprocessing, by notification of overpayment, or through the subrogation process. In addition, the rights of reimbursement and subrogation apply whether or not you or your dependent have been fully compensated for losses or damages by any recovery of payments, and the Health Plan will be entitled to immediately collect the present value of subrogation rights from said payments.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, medical payments coverage, other substitute coverage, or any other right of recovery, whether based on tort, contract, equity, or any other theory of recovery. The Health Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, noneconomic damages, and general damages, or a combination of the above, only. The right of reimbursement is binding upon you, your legal representative, your heirs, next of kin, and any trustee or legal representative of your heirs or next of kin in the event of your death. Any amounts you receive from such a recovery must be held in trust for the Health Plan's benefit to the extent of subrogation or reimbursement claims. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made from such constructive trust until the Health Plan's subrogation and reimbursement interests are fully satisfied. You agree to cooperate fully in every effort by the Health Plan to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to inform the Health Plan in writing within 30 days of giving notice to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents also agree to provide written notice to the Health Plan prior to receipt of any recovery or within 5 days if no notice was given prior to your receipt of the funds.

Recovery of overpayments

If the Health Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Health Plan has the right to recover the excess amount paid. Both the plan administrator and the applicable claims administrator have the right to conduct recovery actions on behalf of the Health Plan. This may be accomplished by any combination of the following:

- Reprocessing of the claim
- Requiring that the overpayment be returned when requested by the claims administrator or the plan administrator, on behalf of the Health Plan
- Reducing or offsetting a future benefit payment for you or your dependent by the amount of the overpayment

Recovery of advanced payments

If the Health Plan provides an advancement of benefits to you or your dependent before you meet the applicable annual deductible, or the applicable annual out-of-pocket maximum, the Health Plan has the right to recover advanced payment of benefits. Both the plan administrator and the applicable claims administrator have the right to conduct recovery actions on behalf of the Health Plan. The claims administrator or the plan administrator, on behalf of the Health Plan, may send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Health Plan has the right to recover benefits it has advanced by pursuing both of the following:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Health Plan
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Health Plan

Reimbursement policy

The right of reimbursement means you must repay the Health Plan at the time you make any recovery. Recovery means all amounts received by you from any persons, organizations, or insurers by way of settlement, verdict, judgment, award, or otherwise, on account of injury or medical condition. The Health Plan will not cover the value of the services to treat such an injury or medical condition, or the treatment of such an injury or medical condition. However, the Health Plan may advance payment to you for these medical expenses if you, or any person claiming through or on your behalf, agree to do both of the following:

- Grant to the Health Plan a first priority lien against any proceeds of any settlement, verdict, or insurance proceeds received by you or on your behalf as a result of the third party's actions and are to be repaid to the Health Plan before you receive any recovery for your damages

- Assign to the Health Plan any benefits you may receive under any automobile policy or other insurance coverage, to the full extent of the Health Plan's claim for reimbursement

You must sign and deliver to the claims administrator or the plan administrator on behalf of the Health Plan, as directed, any documents needed to protect the Health Plan's lien or to affect the assignment of your benefits. You must also agree not to take any action that is inconsistent with the Health Plan's right to reimbursement. Reimbursement will be made regardless of whether you are fully compensated, or "made whole," by the settlement, verdict, judgment, award, or insurance proceeds and regardless of whether costs are allocated to "medical expenses." The Health Plan will not be responsible for bearing the cost of any legal fees you incur as a result of any action you take against the third party. If, after recovery of any payments, you receive services or incur expenses on account of such injury or medical condition, you may be required to pay for such services or expenses. The total of all reimbursement and payments will not exceed your recovery.

If you refuse to fully reimburse the Health Plan after receipt of a settlement, verdict, judgment, award, or insurance proceeds, the Health Plan may not pay for any future medical expenses, whether anticipated or unanticipated, relating to your injury or medical condition. In addition, the Health Plan may seek legal action against you to recover paid medical benefits related to your injury or medical condition. In addition, the Health Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent covered expenses are paid by the Health Plan.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator, in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Subrogation

Under the reimbursement method of subrogation, you reimburse the Health Plan any money you receive through a settlement, verdict, judgment, award, or insurance proceeds. At its sole discretion, the Health Plan also has the option of directly asserting its rights against the third party through subrogation. This means that the Health Plan is subrogated to all of your rights against any third party who is liable for your injury or medical condition. The Health Plan may also be subrogated for the payment for the medical treatment of your injury or medical condition, to the extent of the value of the medical benefits provided to you by the Health Plan. The Health Plan may make a claim in your name or the Health Plan's name against any persons, organizations, or insurers on account of such injury or medical condition. The Health Plan may assert this right independently of you.

You are obligated to cooperate with the Health Plan and its agents to protect the Health Plan's subrogation rights. Cooperation means providing the Health Plan or its agents with any relevant information as requested, signing and delivering such documents as the Health Plan or its agents request to secure the Health Plan's subrogation claim, and obtaining the Health Plan's consent or its agent's consent before releasing any third party from liability for payment of your medical expenses. If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Health Plan. Any costs incurred by the Health Plan in matters related to subrogation may be paid for by the Health Plan. The costs of legal representation you incur will be your responsibility.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Interpretation

In the event that any claim is made that any part of this "Right of Recovery" section is ambiguous, or questions arise concerning the meaning of the intent of any of its terms, the plan administrator or its designee shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this "Right of Recovery" section. The Health Plan's rights reflected in this "Right of Recovery" section are in addition to and not in lieu of any similar rights the Health Plan may have in connection with the dental or visions benefit options under the Health Plan.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to you or made on behalf of you to any provider) from the Health Plan, you agree that any court proceeding with respect to this right of recovery section may be brought in any court of competent jurisdiction as the Health Plan or its designee may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond to you by reason of your present or future domicile.

The basics

Express Scripts administers the prescription drug benefits offered under the:

- Copay Plan with HRA*
- Higher Use Plan with HSA*
- Lower Use Plan with HSA*
- Narrow Network Plan with HSA
- Narrow Network Copay Plan
- Flex HDHP*

* Including Out of Area. Unless otherwise indicated, references in this "Prescription drug benefit" section to the Copay Plan with HRA or the Higher Use Plan with HSA and Lower Use Plan with HSA also apply to the applicable Out of Area coverage.

Prescriptions must be written by a medical provider licensed to prescribe medications. Coverage is determined based on Express Scripts' coverage criteria. In addition, all prescriptions are subject to the limitations, exclusions, and procedures described in this "Prescription drug benefit" section of the chapter. Not all medications are covered by the prescription drug benefit (even if other medications in the same therapeutic class are covered). To obtain information on the established criteria, or to find out if your drug is on the Express Scripts National Preferred Drug List (a listing of preferred drugs), is covered, or is subject to certain prescription drug benefit provisions, visit express-scripts.com or call Express Scripts Member Services at 1-855-388-0352.

Filling your prescription

Where you fill your medication will depend on the type of medication you take.

Short-term medications

Short-term medications are generally those you take for less than 90 days. They may be antibiotics or a short-term prescription for a pain medication.

You can fill up to a 30-day supply of your prescription at any retail pharmacy, but you can take advantage of discounted network rates if you use a pharmacy that participates in the Express Scripts retail pharmacy network. When you have a prescription filled at an in-network retail pharmacy, you'll typically pay less than if you have a prescription filled at a nonparticipating pharmacy.

Maintenance medications

Maintenance medications are those you take on a regular, ongoing basis for chronic, long-term conditions such as those used to control blood pressure. This does not include drugs your doctor prescribes for a short-term condition, such as antibiotics.

Generally, you will pay less for your maintenance medications if you fill a 90-day supply through Express Scripts Home Delivery or at a CVS Pharmacy store. As long as your doctor writes a prescription for a 90-day supply for the maintenance medications, the total cost of the medication will generally be less than the cost of purchasing multiple 30-day supplies for the same medication.

Specialty medications

Specialty medications are used to manage long-term (chronic), rare, and complex conditions or genetic disorders. These include, but are not limited to, rheumatoid arthritis, cancer, fertility, infertility, multiple sclerosis, growth hormone disorders, and immune deficiencies. The medications are often injectable or intravenously (IV) infused, but may also be taken orally or inhaled. They may have special storage and handling needs and cost more than other drugs because of the way the drugs are made. Specialty medications must be filled through Accredo, your specialty pharmacy. See the "Accredo, your specialty pharmacy" starting on page 2-153 for more information. Also, certain specialty drugs on the SaveOnSP drug list may be free of charge for you if you enroll in the SaveOnSP program. See the "SaveOnSP Program" section on page 2-148 for more information.

Filling your prescription at a retail pharmacy

Bring your Express Scripts ID card and pay your portion, as shown in the "What you'll pay for prescriptions: Copay Plan with HRA and Narrow Network Copay Plan" table on page 2-150, or in the "What you'll pay for prescriptions: Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, and Flex HDHP" table on page 2-151, for up to a 30-day supply of each prescription, depending on the medical plan in which you are enrolled. Some drugs require pre-service authorization, so be sure to review the "Some prescriptions may require pre-service authorization, step therapy, or quantity limits" section starting on page 2-153 before filling a prescription for the first time.

If you use an out-of-network retail pharmacy, you'll be asked to pay 100% of the prescription price at the pharmacy and then file a paper claim form with the original prescription receipt to Express Scripts. If it's a covered prescription, Express Scripts will reimburse you as shown in the "What you'll pay for prescriptions: Copay Plan with HRA and Narrow Network Copay Plan" table on page 2-150, or in the "What you'll pay for prescriptions: Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, and Flex HDHP" table on page 2-151, for up to a 30-day supply per prescription, depending on the medical plan in which you are enrolled.

To locate an Express Scripts participating pharmacy:

- Visit Express Scripts' website at express-scripts.com.
- Call Express Scripts Member Services at 1-855-388-0352.

Filling your prescription through Express Scripts Home Delivery

Express Scripts Home Delivery is available for most prescriptions that you take on a regular basis. You can order up to a 90-day supply of your prescription. Consult with your doctor regarding your prescription if you intend to use Express Scripts Home Delivery. You will generally pay less if you order a 90-day supply of your medication through Express Scripts Home Delivery.

With Express Scripts Home Delivery, you get:

- Up to a 90-day supply of covered drugs for one copay (see the "What you'll pay for prescriptions: Copay Plan with HRA and Narrow Network Copay Plan" table on page 2-150, or the "What you'll pay for prescriptions: Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, and Flex HDHP" table on page 2-151)
- Access to registered pharmacists 24 hours a day, 7 days a week
- Ability to refill orders online, by phone, or by mail — at any time of the day or night
- Free standard shipping (overnight or second-day delivery may be available in your area for an additional charge)

Although most prescriptions taken on a regular basis can be ordered through Express Scripts Home Delivery, certain medications are not available through home delivery, are not able to be written for up to a 90-day supply, or are subject to additional pharmacy regulations. Prescriptions that may have such limitations may include but are not limited to controlled substances such as certain pain medications or attention deficit disorder drugs. Certain drugs have limits on the quantity that can be dispensed, as determined by Express Scripts. If your quantity is limited based on clinical guidelines or by an Express Scripts program, your copay amount may be prorated, as determined by Express Scripts.

Ordering prescriptions

Once you have filled a prescription through Express Scripts Home Delivery, you can order refills by mail in three ways. It is recommended that you order your refill 14 days before your current prescription runs out. Suggested refill dates will be included on the prescription label you receive from Express Scripts.

Three ways to order prescriptions:

- **Online.** Go to express-scripts.com. If you are a first-time visitor, you'll need to register using your Express Scripts ID number (shown on your Express Scripts ID card).
- **By phone.** (existing prescriptions only)

  Call Express Scripts Member Services at 1-855-388-0352 for fully automated refill service. Have your Express Scripts ID number ready.
- **By mail.**
  - For existing prescriptions:

    Complete a home delivery order form (available on express-scripts.com), attach the refill label provided with your last order, and enclose your payment with your order.
  - For new prescriptions:

    Complete a home delivery order form (available on express-scripts.com), send it to Express Scripts along with your prescription, and enclose your payment with your order.

You can expect your medicine to arrive approximately 10 calendar days after Express Scripts receives your prescription. If you are currently taking a medication, it is recommended that you have at least a 14-day supply on hand when you order to ensure that you do not run out of your current supply before you receive your refill.

Overnight or second-day delivery may be available in your area for an additional charge.

Your package will include a new home delivery order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medicine that you would receive from a retail pharmacy.

Not all prescription drugs are available via mail due to state and federal regulations.

Note: Prescription drugs received via home delivery cannot be returned. You will be responsible for the applicable cost-share for prescription drugs you or your physician orders via mail.

Covered prescriptions

For your prescription to be covered, it must meet Express Scripts' coverage criteria. In addition, all prescriptions are subject to the limitations, exclusions, and procedures described in this chapter. When more than one definition or provision applies, the most restrictive applies and exclusions take precedence over general benefits descriptions.

The following prescription types are generally covered, but some may require pre-service authorization (also known as pre-authorization, pre-approval, prior approval, prior authorization, pre-notification, pre-certification, or pre-auth), may be limited in the amount you can get at any one time, may be limited by the age of the patient, or may be limited to a specific pharmacy:

- Drugs that legally require a prescription, including compounded drugs where at least one ingredient requires a prescription, subject to the exceptions listed in this section
- Diabetic test strips, alcohol swabs, and lancets
- Insulin, insulin pen, insulin prefilled syringes, needles, and syringes for self-administered injections
- Certain preventive over-the-counter drugs or items as required by federal law

The list of preferred drugs, covered drugs, noncovered drugs, and coverage management programs and processes is subject to change at any time without prior notice. As new drugs become available, they will be considered for coverage under the prescription drug benefit.

No cost-share preventive medications

The Affordable Care Act (ACA) requires that certain medications be covered at 100%. The following list of prescription drug classes and specific over-the-counter medications may be available to you with no cost-share. Only certain products within a class may be covered, or you may be asked to try a generic product before a brand name will be covered. Coverage is subject to ACA requirements, clinical guidelines, and all other plan provisions. **Note:** A prescription is required for all claims, including over-the-counter items.

- Aspirin products for men and women less than 70 years old
- Female contraceptives (see the "Women's preventive health care services" section starting on page 2-135)
- Folic acid for men and women through age 50
- Fluoride supplements for children age 6 months through 5 years
- Generic tamoxifen and generic raloxifene when prescribed for the prevention of breast cancer (automatically covered at 100% for all women over age 35; if you are taking the drug for the prevention of breast cancer and do not fall within this group, contact Express Scripts)
- Low to moderate dose statins for men and women ages 40 – 75

See the "Preventive care services (eligible preventive care services)" section starting on page 2-114 and the "Women's preventive health care services" section starting on page 2-135 for information about other covered preventive care under the medical plan.

Patient Assurance Program℠

Effective January 1, 2020, Wells Fargo is participating in the Patient Assurance Program℠ administered by Express Scripts. If you fill a prescription for a participating insulin product on the national preferred drug list your maximum out-of-pocket cost will be $25.00 for a 30-day supply and $75.00 for a 90-day supply (90-day supplies are only available at CVS pharmacy or through Express Scripts Home Delivery (mail order)). You must use a network pharmacy or Express Scripts Home Delivery (mail order) to receive the discount. To confirm if your insulin is on the Patient Assurance Program℠ list visit express-scripts.com/wf. The list is located under "Explore your plan options", within "Your Plan" and "Your Type".

Note: The insulin on the Patient Assurance Program℠ list is subject to change and this program may be discontinued at any time.

Insulin pump supplies and continuous glucose monitor supplies

Certain supplies related to the use of insulin pumps and continuous glucose monitors are covered at 100%. This does not include insulin, medications, swabs, or the devices. Note that not all insulin pump and continuous glucose monitor supplies or all brands are covered by the pharmacy benefit; some supplies are covered under the durable medical equipment benefit. Contact Express Scripts for information about covered supplies.

Express Scripts offers a program called Livongo to help manage diabetes. Livongo is offered to employees and their covered dependents enrolled in one of the following medical plans: Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, or Narrow Network Copay Plan.

When you enroll in the Livongo program you will get a connected meter that automatically uploads your blood glucose readings to your secure online account and provides real-time personalized tips. You get access to coaches that can provide you support, and you get unlimited strips, all at no cost to you. Enroll today by going to join.livongo.com.

SaveOnSP Program

If you participate in the Copay Plan with HRA or the Narrow Network Copay Plan and you take a specialty medication, you may be eligible for the SaveOnSP program administered by Express Scripts and SaveOnSP. With this program, you are eligible to receive specialty medications, if they are on the SaveOnSP Drug List, at no cost as long as you are enrolled in the manufacturer copay assistance program and agree to participate in the SaveOnSP program. Please visit www.saveonsp.com/wellsfargo or call 800-683-1074 to see if your medication is included in the program and to view the cost share that will apply if you do not agree to participate in the program. If your medication is included on the SaveOnSP Drug List and you do not agree to participate in the SaveOnSP program, you will be responsible for the full amount of the cost share for that medication as given on the SaveOnSP Drug list. This amount will not be applied toward satisfying your out of pocket maximum.

Manufacturer assistance programs/out-of-pocket protection program

Pharmaceutical manufacturers may offer payment assistance to offset your copayments or cost share for specialty drugs under the plan. While you may continue to accept manufacturer assistance to offset your out-of-pocket cost, the manufacturer assistance portion of the payment will not apply to your deductible and/or out-of-pocket maximums. If you receive manufacturer assistance, your deductible and/or out-of-pocket maximums will be adjusted following receipt of your prescription to reverse the impact of manufacturer assistance and will reflect only the amount you paid out of pocket (excluding the manufacturer assistance). The adjustments will occur nightly, and you will receive a monthly notice of any applicable adjustments.

Compound drugs

The copay for compound medications will be based on the amount submitted by the compounding pharmacy, or 150% of the average wholesale price, whichever is lower. Ingredients that are not covered under the plan provisions will not be covered as part of a compound. For example, over-the-counter products that are commonly included in compounds such as Benadryl, Maalox, Eucerin, and hydrocortisone that are not covered under the plan will not be covered in a compound.

The compounded formulation must be covered and, if it is reformulated, it must meet FDA-approved guidelines for the condition. Coverage is provided for compounds when they are used in accordance with FDA-approved indications, supported uses, and routes of administration found in medical compendia or other current accepted practice guidelines. All other plan provisions apply.

Some diabetic medications, insulins, and supplies are subject to pre-service authorization requirements. (See the "Some prescriptions may require pre-service authorization, step therapy, or quantity limits" section starting on page 2-153 for more information.)

Note: In the Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, and Flex HDHP, if your drug or supply is not on the preventive therapy drug list, you must meet the annual deductible before benefits are available.

Fertility solutions (including infertility) drugs

Fertility solution medications (including infertility) are covered up to a lifetime maximum benefit of $10,000. You will pay the applicable deductible or copay for the medication. The cost of the medication covered by the Plan applies to the lifetime maximum benefit. Most fertility solutions medications are subject to pre-service authorization requirements. For coverage under the plan up to the lifetime maximum benefit, you must purchase your fertility and infertility medications through Accredo/Freedom Fertility. (See the "Some prescriptions may require pre-service authorization, step therapy, or quantity limits" section starting on page 2-153 for more information.) Medications for donors and partners (for example, suppression medications or stimulation medications) for anyone not enrolled in the plan, including a donor, are not covered. To determine your accrued Lifetime maximum benefit, log into express-scripts.com and go to ***Benefit Plan Balances*** to determine balances. Or you can call Express Scripts and speak to a Patient Care Advocate and ask for balance.

National Preferred Drug List

Certain prescription drugs are included on the Express Scripts National Preferred Drug List. This list, sometimes called a formulary, includes a wide selection of generic and brand-name drugs. Express Scripts maintains the Express Scripts National Preferred Drug List, including ensuring that the list is reviewed and updated regularly by an independent pharmacy and therapeutics committee. The list is continually revised by Express Scripts to ensure that the most up-to-date information is taken into account. Go to express-scripts.com or call 1-855-388-0352 to see if your prescription is on the list.

Drug categories

The prescription drug benefit categorizes prescriptions as follows:

- **Generic prescription drugs.** Generic drugs generally cost less than therapeutically equivalent brand-name drugs.

  The Food and Drug Administration (FDA) ensures that generic drugs meet the same standards for safety and effectiveness as their brand-name equivalents.

  Most drugs that are no longer under patent protection may be available in a generic form from multiple manufacturers. Express Scripts determines which drugs are considered generic based on data from an industry standard independent third party. It is unusual, but possible, for a drug to be classified as a generic and then to be reclassified as a brand at a later time. If you are prescribed such a drug, contact your provider for treatment options.

- **Preferred brand-name drugs.** Brand-name prescription drugs that are on the National Preferred Drug List as determined by Express Scripts.

  These drugs may or may not have generic equivalents available.

- **Nonpreferred brand-name drugs.** Brand-name prescription drugs that are not on the National Preferred Drug List as determined by Express Scripts.

  You'll generally pay more for nonpreferred brand-name drugs covered under the plan.

- **Biosimilars.** A biosimilar product is a biological product that is approved based on a showing that it is highly similar to an already-approved biological product. The biosimilar also must show it has no clinically meaningful differences in terms of safety and effectiveness. Only minor differences in clinically inactive components are allowable in biosimilar products.

What you'll pay for prescriptions: Copay Plan with HRA and Narrow Network Copay Plan

You do not pay a deductible for prescription drug costs and prescription drug copays do not count toward your medical annual deductible; however, copays do count toward your annual out-of-pocket maximum. See the "Important terms" section starting on page 2-12 for more information about the annual deductible and annual out-of-pocket maximum. See the "No cost-share preventive medications" section starting on page 2-148 for more information about certain preventive drugs covered at 100%.

Note: For the Copay Plan with HRA, you may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" starting on page 2-15 for more information.

Type of drug	**In-network retail pharmacy** (up to a 30-day supply)	**Out-of-network retail pharmacy** (up to a 30-day supply)	**Express Scripts Home Delivery** (up to a 90-day supply) **or CVS Pharmacy store** (31- to 90-day supply)
Generic	You pay a $10 copay.[1, 2] **Note:** Generic contraceptives are covered at 100%.	You pay a $10 copay.[1, 2] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $20 copay.[1, 2] **Note:** Generic contraceptives are covered at 100%.
Preferred brand-name drugs	You pay a $45 copay.[1, 2, 3]	You pay a $45 copay.[1, 2, 3] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $90 copay.[1, 2, 3]
Nonpreferred brand-name drugs	You pay a $75 copay.[1, 2, 3]	You pay a $75 copay.[1, 2, 3] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $150 copay.[1, 2, 3]
Specialty medications (this includes infertility and fertility drugs)	Not covered.	Not covered.	Only covered through Accredo specialty pharmacy delivery. You pay a $150 copay for a 90-day supply (copay is prorated for 30- or 60-day supply).[1, 2, 4, 5]

1. The deductible does not apply.
2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum.
3. When you purchase a brand-name drug and a generic is available, you will pay the generic drug copay plus the difference in cost between the generic and brand-name drug.
4. Manufacturer assistance does not apply toward your deductible and out-of-pocket maximums. If you receive manufacturer assistance, your deductible and out-of-pocket maximums will be adjusted following receipt of your prescription to reflect the amount you paid out of pocket (excluding the manufacturer assistance).
5. If your medication is included in the SaveOnSP program, you are eligible to receive your medication for no cost. If your medication is included on the SaveOnSP Drug List and you do not agree to participate in the SaveOnSP program, you will be responsible for the full amount of the cost share on the SaveOnSP Drug list. This amount will not be applied toward satisfying your out-of-pocket maximum. Visit www.saveonsp.com/wellsfargo or call 800-683-1074 to see if your drug is included in the program.

What you'll pay for prescriptions: Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, and Flex HDHP

You must satisfy your applicable annual deductible under the Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, or Flex HDHP before you begin paying the copay amounts listed in the table below, unless your drug is on the preventive therapy drug list. If your prescribed drug is on the preventive therapy drug list, you pay the copay amounts listed in the table below regardless of whether you have met your annual deductible or not. The copay amounts do not count toward your annual deductible, but they do count toward your annual out-of-pocket maximum. Go to express-scripts.com or call Express Scripts at 1-855-388-0352 to see if your prescription is considered to be a preventive therapy drug. See the "Important terms" section starting on page 2-12 for more information about the annual deductible and annual out-of-pocket maximum. See the "No cost-share preventive medications" section starting on page 2-148 for more information about certain preventive drugs covered at 100%.

Type of drug	**In-network retail pharmacy** (up to a 30-day supply)	**Out-of-network retail pharmacy** (up to a 30-day supply)	**Express Scripts Home Delivery** (up to a 90-day supply) **or CVS Pharmacy store** (31- to 90-day supply)
Medications on the preventive therapy drug list	You do not need to meet the deductible. You pay: • $10 copay for generic[1] **Note:** Generic contraceptives are covered at 100%. • $45 copay for preferred brand-name drugs[1, 2] • $75 copay for nonpreferred brand-name drugs[1, 2]	You do not need to meet the deductible. You pay: • $10 copay for generic[1] • $45 copay for preferred brand-name drugs[1, 2] • $75 copay for nonpreferred brand-name drugs[1, 2] You also pay the difference between the full cost and the Express Scripts discounted amount.	You do not need to meet the deductible. You pay: • $20 copay for generic[1] **Note:** Generic contraceptives are covered at 100%. • $90 copay for preferred brand-name drugs[1, 2] • $150 copay for nonpreferred brand-name drugs[1, 2]
Generic	You pay a $10 copay after you satisfy the deductible. **Note:** Generic contraceptives are covered at 100%.	You pay a $10 copay after you satisfy the deductible. You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $20 copay after you satisfy the deductible. **Note:** Generic contraceptives are covered at 100%.
Preferred brand-name drugs	You pay a $45 copay after you satisfy the deductible.[2]	You pay a $45 copay after you satisfy the deductible.[2] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $90 copay after you satisfy the deductible.[2]
Nonpreferred brand-name drugs	You pay a $75 copay after you satisfy the deductible.[2]	You pay a $75 copay after you satisfy the deductible.[2] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $150 copay after you satisfy the deductible.[2]
Specialty medications (this includes infertility and fertility drugs)	Not covered.	Not covered.	Only covered through Accredo specialty pharmacy delivery. You pay a $150 copay for a 90-day supply after you satisfy the deductible (copay is prorated for 30- or 60-day supply).[3]

1. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum.

2. When you purchase a brand-name drug and a generic is available, you will pay the generic drug copay plus the difference in cost between the generic and brand-name drug.

3. Manufacturer assistance does not apply toward your deductible and out-of-pocket maximums. If you receive manufacturer assistance, your deductible and out-of-pocket maximums will be adjusted following receipt of your prescription to reflect the amount you paid out of pocket (excluding the manufacturer assistance).

Preventive therapy drug list

Preventive medications are those generally prescribed to people who may be at risk for certain diseases or conditions and are not used to treat an existing illness or condition, even if the drug may prevent the illness or condition from progressing. The preventive therapy drug list reflects guidance provided by the U.S. Department of Treasury indicating that certain drugs could be covered as preventive for selected conditions under a High-Deductible Health Plan (HDHP). The preventive therapy drug list is subject to change.

Go to express-scripts.com or call Express Scripts Member Services at 1-855-388-0352 to see if your prescription is considered to be a preventive therapy drug. See the "No cost-share preventive medications" section starting on page 2-148 for information about certain preventive drugs covered at 100%.

Additional prescription drug coverage provisions

The following provisions also apply to all prescription drug claims processing under the Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, the Narrow Network Copay Plan, and the Flex HDHP:

- In some cases, the full cost of a drug may be less than the copay, if applicable. In those cases, you will pay the lower amount.
- It's standard practice in most pharmacies (and, in some states, a legal requirement) to substitute generic equivalents for brand-name drugs whenever possible.
- If a biosimilar drug is available, you may be required to try a biosimilar before a brand-name reference product will be covered.
- Generic and some single-source brand-name contraceptives, filled at an in-network retail pharmacy, are covered at 100%. For more information on what's covered at 100%, contact Express Scripts Member Services at 1-855-388-0352. If there is a clinical reason that you cannot take a generic contraceptive, your doctor can submit a request to Express Scripts for review. If the request is approved, your brand-name contraceptive will be covered at 100%. Your doctor must submit a request for pre-service authorization review electronically. Information about electronic options can be found at express-scripts.com/PA. For questions about the pre-service authorization process, call 1-855-388-0352.
- If you purchase a brand-name drug when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand-name drug and the generic drug. The difference in cost between the brand-name drug and the generic drug will be calculated using the full cost of the brand-name drug before any associated rebate is applied to reduce the cost of the brand-name drug. The full cost of the brand-name drug before application of any associated rebate may be higher than the cost of the brand-name drug as disclosed by Express Scripts' pricing tools and cost estimates. Any difference in cost between the brand-name and generic is not applied to any applicable deductible, maximum per prescription amount, or to any out-of-pocket maximum listed above. If there is a clinical reason that you cannot take a generic drug, your doctor can submit a request to Express Scripts for review. If the request is approved, you will pay the applicable nonpreferred brand-name drug cost amount listed above. Your doctor can fax the request to the Express Scripts Appeals Department at 1-877-328-9660.
- There are no exceptions to any copay or copay tiers listed, even with a physician's request. For example, if the drugs on the National Preferred Drug List are not appropriate for you, and you choose a drug that's not on the list, you will still have to pay the higher copay.
- Prescriptions for certain specialty drugs (typically self-injectables, drugs that require special handling such as infertility and fertility drugs, or oral chemotherapy drugs) cannot be filled at retail pharmacies. For more information, see the "Accredo, your specialty pharmacy" starting on page 2-153.
- Express Scripts Home Delivery is the only covered mail order provider. Any drugs ordered by mail from another provider or service will not be covered.
- Certain prescriptions have quantity limits based on FDA, manufacturer, or clinical guidelines, as determined by Express Scripts.
- You'll need to request pre-service authorization from Express Scripts for certain prescriptions. For more information, see the "Some prescriptions may require pre-service authorization, step therapy, or quantity limits" section starting on page 2-153.
- Special rules may apply if you receive manufacturer assistance, see the "Manufacturer assistance programs/out-of-pocket protection program" section on page 2-148 for more information.

Your ID card

Shortly after you enroll in the Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, the Narrow Network Copay Plan, or the Flex HDHP, you'll receive an ID card from Express Scripts. You'll need to present your ID card each time you purchase prescription drugs at a participating pharmacy. If you do not have your ID card with you, you can pay for your prescription up front and file a claim for reimbursement with Express Scripts.

You can also go to express-scripts.com to print an ID card.

Accredo, your specialty pharmacy

Complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis are treated with specialty drugs. These are typically drugs that are self-injectable or require special handling, or oral chemotherapy drugs. Accredo is a comprehensive specialty pharmacy that provides these products directly to covered individuals along with supplies, equipment, and care coordination.

Contact Accredo toll-free at 1-877-830-9019 to get:

- Personal attention from experts specializing in your specific conditions
- Expedited, confidential delivery to the location of your choice
- A specialty-trained pharmacist or nurse to provide customized care, counseling on how to best manage your condition, patient education, and evaluations to assess your progress on therapy and to discuss your concerns
- Specialty-trained pharmacists who are available 24 hours a day for emergency consultations
- Coordination of home care and other health care services

Certain specialty medications may not be available through the Accredo specialty pharmacy due to limited distribution from the manufacturer. If you fill a limited distribution specialty drug, you will pay the retail pharmacy copay or cost-share amount. See the applicable "What you'll pay for prescriptions: Copay Plan with HRA and Narrow Network Copay Plan" table on page 2-150 or the "What you'll pay for prescriptions: Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, and Flex HDHP" table on page 2-151 for more information.

Certain specialty drugs have limits on the quantity that can be dispensed, as determined by Express Scripts. If your quantity is limited based on clinical guidelines or by an Express Scripts program, your copay may be prorated, as determined by Express Scripts.

Some prescriptions may require pre-service authorization, step therapy, or quantity limits

With most of your prescriptions, no pre-service authorization is necessary. However, some prescriptions require that you get authorization from Express Scripts in order to have the prescription covered by the plan. This pre-service authorization review must be conducted before the prescription can be filled and coverage provided under the prescription drug benefit. This pre-service authorization may also be referred to as pre-authorization, pre-approval, prior approval, prior authorization, pre-notification, pre-certification, or pre-auth. Many of the drug classes requiring pre-service authorization are listed on the next page. Contact Express Scripts to determine if your prescription requires pre-service authorization; visit express-scripts.com, sign on, and click Prescriptions and Price a Medication to search for your medication by name, or contact Express Scripts Member Services at 1-855-388-0352.

When you receive a prescription, take it to your retail pharmacy or fill it through Express Scripts Home Delivery as described in this chapter. If pre-service authorization is necessary, your pharmacist or Express Scripts will let you know. If pre-service authorization is required, the provider who prescribed the medication must visit esrx.com/PA or call 1-800-417-1764 to submit pertinent information to Express Scripts that is necessary for the pre-service authorization review. If you pay out of pocket for your prescription before obtaining the pre-service authorization and your pre-service authorization is approved thereafter, the plan will not be responsible for any cost above the contracted rate.

After the review is complete, Express Scripts will send you and your doctor a letter confirming whether coverage has been approved (usually within 48 hours after Express Scripts receives the information it needs).

If coverage is approved, you'll pay the applicable deductible, copay, or cost for your prescription as listed in the applicable "What you'll pay for prescriptions: Copay Plan with HRA and Narrow Network Copay Plan" table on page 2-150 or the "What you'll pay for prescriptions: Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, and Flex HDHP" table on page 2-151. If coverage is not approved, you will be responsible for the full cost of the medication. If coverage is denied, you have the right to appeal the decision. Information about the appeal process will be included in the notification letter you receive (also see "Appendix A: Claims and Appeals").

General pre-service authorization

Sometimes doctors write prescriptions that are "off label" (meaning not for the purpose for which the drug is normally used) or there may be specific criteria that must be met in order for the prescription to be covered. To ensure certain medications meet the coverage criteria, a pre-service authorization review is required for some drugs.

Step therapy

Some drugs require what's called "step therapy." This means you may need to try one or more generic, biosimilar, or preferred brand-name drugs before certain drugs are covered. Drugs requiring step therapy are also subject to pre-service authorization review.

Quantity limits

Some drugs are limited in the quantity that can be dispensed by law, according to the manufacturer's guidelines for use, or by Express Scripts in its sole discretion. Drugs with quantity limits are also subject to pre-service authorization review.

List of drugs and conditions subject to pre-service authorization, step therapy, or quantity limits

The list of drugs and conditions below that require pre-service authorization or step therapy, or that may be subject to quantity limits, may change at any time without prior notice. As new prescription drugs, generic drugs, and additional information about existing drugs become available, they will be considered for coverage under the prescription drug benefit as they are introduced. For current information on medications that may require pre-service authorization, require step therapy, or have quantity limits, please contact Express Scripts. The following table provides information about many of the drug classes subject to these requirements.

Drug class or condition treated	Pre-service authorization required	Step therapy required	Quantity limits apply
Acne medications	X	X	
Acromegaly	X		
Alcohol and opioid dependency	X		
Allergies	X	X	X
Alzheimer's disease	X	X	
Anabolic steroids	X		
Analgesics	X		
Anemia	X	X	
Antiandrogens	X		
Anticonvulsants	X	X	
Antiemetics (treat nausea and vomiting)	X		X
Anti-Infectives, IV and Nasal Rinse	X		
Anti-infectives, topical	X		X
Antifungals, topical	X		X
Antiobesity medications	X		
Asthma	X	X	X
Attention deficit hyperactivity disorder (ADHD)	X		
Beta blockers/Beta blocker combination	X	X	
Botulinum toxins	X		
Cancer treatments	X	X	
Cardiac disorder	X		
Carnitine deficiency agents	X		
Central precocious puberty (CPP)	X		
Cholesterol medications	X	X	
CNS — Huntington's disease	X		
Coagulation disorders (affect blood clotting)	X		
Contraceptives (when you can't use generic)	X	X	
Corticosteroids	X		
Cryopyrin-associated periodic syndromes (CAPS)	X	X	
Cushing's syndrome	X		
Cystic fibrosis	X		X
Depression	X	X	
Dermatology	X	X	
Diabetes glucose test strips	X	X	
Diabetes medications	X	X	X
Duchenne Muscular Dystrophy (DMD agents)	X		
Electrolyte disorders	X		X

Drug class or condition treated	Pre-service authorization required	Step therapy required	Quantity limits apply
Emphysema	X		X
Enlarged prostate	X	X	
Fertility, see “Infertility” row below			
Fibrates	X	X	
Gastrointestinal disorders	X		
Gaucher disease	X	X	
Glaucoma	X	X	
Gout	X	X	
Growth hormone	X	X	
Hematopoietics	X		
Hemophilia	X		
Hepatitis C	X	X	X
Hereditary angioedema	X		
High blood pressure	X	X	X
Hormonal therapies	X		X
Idiopathic Pulmonary Fibrosis	X		X
Immune globulins	X		
Immune (Idiopathic) thrombocytopenia purpura (ITP)	X		
Influenza prevention			X
Infertility	X	X	X
Interferon agents	X		
Iron overload	X		
Irritable bowel disease	X	X	
Kidney disorders	X		
Lipid disorders	X		
Lysosomal storage disease	X		
Metabolic Disorders	X		
Migraine medications	X	X	X
Movement disorders	X		
Multiple sclerosis	X	X	
Muscular dystrophy	X		
Narcolepsy	X	X	X
Nasal steroid combinations	X	X	
Neutropenia	X		X
NSAIDs	X	X	X
Ophthalmic anti-allergic	X	X	
Ophthalmic anti-inflammatory	X	X	
Ophthalmic Dry Eye Disease			X
Opioid analgesics and agonists	X	X	
Osteoarthritis	X		
Osteoporosis	X	X	X
Overactive Bladder			X

Drug class or condition treated	Pre-service authorization required	Step therapy required	Quantity limits apply
PAH endothelin-receptor agonists	X	X	
Pain	X	X	X
Pancreatic enzymes	X	X	
Parkinson's disease	X		
Paroxysmal nocturnal hemoglobinuria (PNH) (red blood cell breakdown)	X		
Phenylketonuria (PKU)	X		
Pheochromocytoma		X	
Preterm birth	X		
Proton pump inhibitors	X	X	X
Psoriasis	X	X	
Pulmonary arterial hypertension	X	X	X
Pulmonary fibrosis	X		
Respiratory epinephrine auto-injectors	X	X	X
Retinal disorders	X		
Rheumatoid arthritis	X	X	X
RSV (infant respiratory virus)	X		
Short-acting beta agonists	X		
Sleep agents	X	X	X
Systemic lupus erythematosus (SLE)	X		
Testosterone replacement	X		
Topical antiviral agents	X	X	
Topical immunomodulators	X		
Topical inflammatory conditions			X
Topical pain			X
Urea cycle disorders	X		
Urinary antispasmodics	X	X	
Wilson's Disease		X	

Prescriptions that are not covered

In addition to any other exclusions, limitations, and services listed as not covered as specified in this chapter, the prescription drug benefit does not cover the following (even if prescribed by a physician, or medically necessary):

- Any drug used to enhance athletic performance.
- Compound drug ingredients as follows: proprietary base ingredients, including but not limited to PCCA Lipoderm Base, PCCA Custom Lipo-Max Cream, VersaBase Cream, VersaPro Cream, PCCA PracaSil Plus Base, Spirawash Gel Base, VersaBase Gel, Lipopen Ultra Cream, Lipo Cream Base, Pentravan Cream/Cream Plus, VersaPro Gel, Versatile Cream Base, PLO Transdermal Cream, Transdermal Pain Base Cream, PCCA Emollient Cream Base, Penderm, Salt Stable LS Advanced Cream, Ultraderm Cream, Base Cream Liposome, Mediderm Cream Base, and Salt Stable Cream.
- Bulk powders, including but not limited to muscle relaxants, analgesics, antidepressants, anti-inflammatory agents, opioids, neuropathic agents, corticosteroids, and androgens.
- Bulk nutrients, including but not limited to vitamins, minerals, electrolytes, and amino acids.
- Bulk compounding agents, including but not limited to surfactants, vehicles, alkalizing agents, antiseptics, disinfectants, and pigments.
- Miscellaneous bulk ingredients, including but not limited to chelating agents, digestive enzymes, keratolytics, and anesthetics.
- Compounded drugs that do not meet the definition of compounded drugs, which are medications in which at least one ingredient is a drug that requires a prescription. Compounded formulation must be covered by the plan and if reformulated must meet FDA-approved guidelines for the condition.

Coverage is provided for compounds when they are used in accordance with FDA-approved indications, supported uses, and routes of administration found in medical compendia or other current accepted practice guidelines. All other plan provisions apply.

- Drugs that are already covered under any government programs, including Workers' Compensation, or medication furnished by any other drug or medical service that you do not have to pay for.
- Drugs that are considered cosmetic agents or used solely for cosmetic purposes (for example, antiwrinkle drugs or drugs for eyelash growth).
- Drugs that are not approved by the FDA, or that are not approved for the diagnosis for which they have been prescribed, or are not approved for the method of administration, unless otherwise approved by Express Scripts based on clinical criteria as determined by Express Scripts in its sole discretion.
- Drugs that require administration by a dental professional (for example, Arestin or PerioChip).
- Drugs that treat hair loss, thinning hair, unwanted hair growth, or hair removal.
- Drugs or supplies that are not for your personal use or that of your covered dependent.
- Drugs whose intended use is illegal, unethical, imprudent, abusive, or otherwise improper.
- Drugs you purchase outside the U.S. that you are planning to use in the U.S.
- Early refills, except in certain emergency situations as approved by Express Scripts in its sole discretion. In these situations, you may receive up to a 30-day supply at a retail pharmacy or a 90-day supply from Express Scripts Home Delivery or from a CVS Pharmacy store. You'll be responsible for the applicable copay.
- High cost drugs in categories with suitable covered therapeutically equivalent products will not be covered by the plan regardless of medical necessity.
- Investigational or experimental drugs in original or compounded form, as determined by Express Scripts in its discretion.
- Mail order prescriptions that are not filled through Express Scripts Home Delivery.
- More than a 30-day supply of a prescription drug at a retail pharmacy, except when you have a prescription written for a 90-day supply and it is filled at a CVS Pharmacy store, even if there is not a CVS Pharmacy store in your area.
- New drugs or new formulations of drugs that have not been reviewed by Express Scripts for safety, efficacy, and cost-effectiveness unless approved by Express Scripts based on clinical criteria as determined by Express Scripts in its sole discretion.
- Nonsedating antihistamines.
- Nutritional supplements, dietary supplements, meal replacements, infant formula, or formula food products.
- Over-the-counter drugs or supplies, including vitamins and minerals or reformulations of over-the-counter drugs (except as may otherwise be required by applicable federal law).
- Prescriptions dispensed after one year from the original date of issue, more than six months after the date of issue for controlled substances, or prescriptions prohibited by applicable law or regulation.
- Prescription drug claims received beyond the 12-month timely filing requirement; Express Scripts must receive claims within 12 months of the prescription drug dispensed date.
- Prescriptions exceeding a reasonable quantity as determined by Express Scripts in its discretion.
- Prescriptions requested or processed after your coverage ends; you must be an active participant in the Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, or the Narrow Network Copay Plan at the time your prescription is processed — not merely on the date your prescription is postmarked — for your prescription to be covered.
- Prescriptions that do not meet Express Scripts' coverage criteria.
- Prescriptions that do not meet the definition of a covered health service (see the "Covered health services definition" section starting on page 2-50).
- Replacement of lost or stolen medication.
- Specialty medications that are not filled through the required Accredo specialty pharmacy delivery.
- Sexual dysfunction drugs.
- Topical antifungal polishes (such as Penlac).

The following drugs are not covered by Express Scripts but may be covered by the medical coverage portion of your medical plan. Typically, these are administered in your doctor's office.

- Contraceptive devices and inserts that require fitting or application in a doctor's office, such as a diaphragm, or intrauterine devices (IUD).
- Prescription drugs that require administration under the direct supervision of a health care professional and the prescription drug is not acquired under the prescription drug benefits as described in this section.
- Immunization agents or vaccines (except Zostavax, Gardasil, influenza vaccine, or Vivotif Berna).
- Therapeutic devices, appliances, and durable medical equipment, except for glucose monitors.

This list is subject to change. To determine if your prescription is covered, visit express-scripts.com or contact Express Scripts Member Services at 1-855-388-0352.

Prescription drug coordination of benefits

The prescription drug benefit does not coordinate with other plans, including Medicare or Medicare Part D. This prescription drug benefit provides primary payment only and does not issue detailed receipts for submission to other carriers for secondary coverage. If another insurance company, plan, or program pays your prescription benefit first, there will be no payments made under this plan. Because there is no coordination of benefits provision for prescription drugs, you cannot submit claims to Express Scripts for reimbursement after any other payer has paid primary or has made the initial payment for the covered drugs.

If you or a covered dependent is covered under the Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, the Narrow Network Copay Plan, or the Flex HDHP and Medicaid or other similar state programs for prescription drugs, in most instances, your prescription drug coverage under your medical plan at Wells Fargo is your primary drug coverage. You should purchase your prescription drugs using your Express Scripts ID card and submit out-of-pocket copay expenses to Medicaid or other similar state programs.

Prescription drug claims and appeals

Express Scripts is the named claims and appeals fiduciary for the prescription drug claims and has sole and complete discretionary authority to determine the applicable claims and appeals in accordance with the terms of the documents or instruments governing the prescription drug benefits under the medical plans.

Filing a prescription drug claim

Urgent care claims

If the prescription drug benefit requires pre-service authorization to receive benefits and a faster decision is required to avoid seriously jeopardizing the life or health of the claimant, your physician must make the urgent care claim request by calling 1-800-753-2851. If you have questions, call Express Scripts Member Services at 1-855-388-0352.

Important: Specifically state that your request is an urgent care claim.

Pre-service claims

If the prescription drug benefit requires pre-service authorization to receive benefits but is not considered an urgent care claim, your physician must submit the request for review electronically. Information about electronic options can be found at express-scripts.com/PA. For questions about the pre-service authorization process, call 1-855-388-0352.

Post-service claims

You will need to file a claim if you buy prescription drugs or other covered supplies from a pharmacy not in the Express Scripts network or if the in-network pharmacy was unable to submit the claim successfully. All claims must be received by Express Scripts within 12 months from the date the prescription drug or covered supplies were dispensed. Claims not submitted within 12 months from the date the prescription drug or covered supplies were dispensed will not be covered.

Your out-of-network claim will be processed faster if you follow the correct procedures. Complete the Prescription Drug Reimbursement form and send it with the original prescription receipts. You may not use cash register receipts or container labels from prescription drugs purchased at an out-of-network pharmacy.

Prescription drug bills must provide the following information:

- Patient's full name
- Prescription number and name of medication
- Charge and date for each item purchased
- Quantity of medication
- Doctor's name

To get a claim form:

- Go to express-scripts.com, sign in, and download the claim form.
- Call Express Scripts Member Services at 1-855-388-0352 to request a form.

Send your claim to:

Express Scripts
Attn: Benefit Coverage Review Department
PO Box 66587
St. Louis, MO 63166-6587
Fax: 1-877-328-9660

You are responsible for any charges incurred but not covered.

Refer to "Appendix A: Claims and Appeals" for more information regarding claims.

Express Scripts claims questions, denied coverage, and appeals

If you have a question or concern about a claim already filed with Express Scripts, you may contact Express Scripts Member Services at 1-855-388-0352.

In the event your claim is denied (in whole or in part), you may also file a formal appeal under the terms of the Health Plan. A formal written appeal must be filed with Express Scripts within 180 days from the date you receive notification that your claim is denied, regardless of any verbal discussions that have occurred regarding your claim. (Exception: Urgent care claim appeals may be requested verbally.) Once you exhaust the internal appeals procedures, you may be entitled to an external review of your claim.

Complete information on appeals is provided in "Appendix A: Claims and Appeals."

Prescription drug right of recovery

For right of recovery provisions, refer to the "Right of recovery" section starting on page 2-144.

Other things you should know

Clinical Management Programs

Through a series of safety checks, Express Scripts clinical management programs help ensure that your prescription drug treatment is appropriate for your health situation. If these safety checks reveal a potential problem, an Express Scripts pharmacy professional or representative will directly contact your physician to review your treatment, and sometimes suggest a change to the current therapy.

Express Scripts will not change your medication without your doctor's consent except for substituting a generic medication for a brand-name drug when a generic equivalent is available, where permitted by applicable law. If a suggested change is authorized, you will be notified by phone, letter, or both, all of which will contain the authorized change.

Express Scripts may contact your doctor about your prescription

Your prescription can be dispensed only as it is written by a physician or other lawful prescriber (as applicable to Express Scripts). Unless you or your doctor specifies otherwise, your prescription will be dispensed with the generic equivalent when available and if permissible by law (as applicable to Express Scripts).

You're not limited to prescriptions on Express Scripts' National Preferred Drug List, but you may pay less if you choose a drug from that list. If your doctor prescribes a drug that is not on the National Preferred Drug List but there's an alternative on the list, Express Scripts may contact your doctor to see if that drug would work for you. However, your doctor always makes the final decision regarding your prescriptions. If your doctor agrees to prescribe a drug that is on the National Preferred Drug List instead of the drug that is not on the list, you will never pay more than you would have for the original prescription, and will usually pay less.

Also, Express Scripts offers consultative services to help manage chronic or long-term conditions, such as diabetes. These services may help you save on pharmacy costs and may help to prevent related complications or disease progression. Through this program, you and your doctor may be contacted via telephone by an Express Scripts pharmacist to discuss your therapy and provide condition and drug-specific counseling.

Prescription drug rebates

Express Scripts administers the prescription drug benefit on behalf of the Wells Fargo & Company Health Plan ("Health Plan"). The Copay Plan with HRA, the Higher Use Plan with HSA, the Lower Use Plan with HSA, the Narrow Network Plan with HSA, the Narrow Network Copay Plan, and the Flex HDHP are all components of the Health Plan. Express Scripts has negotiated certain rebates and discounts with participating retail pharmacies and drug manufacturers. For prescription drugs eligible for a rebate, the rebate may be taken into account in determining your out-of-pocket costs. The prescription drugs that may be eligible for a rebate and the rebate amount (if any) will change from time to time.

To the extent the Health Plan receives discounts or rebates based on Express Scripts' negotiated rebates and discounts that exceed amounts taken into account in determining the out-of-pocket costs by Health Plan participants, such amounts will belong solely to the Health Plan and shall be held for the exclusive purpose of providing benefits to Health Plan participants and beneficiaries and defraying reasonable expenses of administering the Health Plan.

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Chapter 3: Dental Plan

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Contacts

Information about benefits, ID cards, claims, providers, or covered services	Delta Dental of Minnesota (Delta Dental) https://www.deltadentalmn.org/wf Minneapolis and St. Paul Metro Area: 651-994-5342 All other areas: 1-877-598-5342
Information about the dental plan options	HR Services & Support site
Information about enrollment	Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.
Information about premiums	HR Services & Support site

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix A: Claims and Appeals," "Appendix B: Important Notifications and Disclosures," "Appendix D: Leaves of Absence and Your Benefits," and "Appendix E: Continuing Coverage Under COBRA" — constitutes the Summary Plan Description (SPD) for the dental benefit options available under the Wells Fargo & Company Health Plan (the Health Plan). The dental benefit options are also referred to as the dental plan.

The basics

General information

The dental plan is a part of the Health Plan. The Health Plan is a group health plan and is classified as a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA). There are two dental coverage options:

- Delta Dental Standard
- Delta Dental Enhanced

You must be enrolled in one of these coverage options on the date of service to receive applicable benefits.

The dental plan and respective coverage options, administered by Delta Dental, are available in all U.S. locations.

The dental plan covers preventive, diagnostic, basic, and major services, as well as orthodontia, for you and your covered dependents.

If you are enrolled in either Delta Dental coverage option, you agree to authorize your provider to give Delta Dental access to required information about your care. Your failure to provide this authorization or any requested information may result in denial of your claim. Delta Dental may require this information to process claims, to conduct quality improvement and utilization review activities, or for other health plan activities, as permitted by law. Delta Dental may release the information, if you authorize it to do so, or if state or federal law permits or allows release without your authorization.

Who's eligible

Regular and fixed term Wells Fargo employees are eligible to enroll in the dental plan. If you are enrolled as an eligible employee, you may also cover your eligible dependents including your spouse or domestic partner. Interns and flexible employees and their dependents are not eligible to enroll in the dental plan. Detailed eligibility requirements are described in the "Who's eligible to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

You may not be covered under the dental plan as both an employee and spouse or domestic partner of another employee, or an employee and a dependent child of another employee at the same time. Also, an eligible dependent can only be covered under one employee.

How to enroll and when coverage begins

Refer to the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment. After you have enrolled, coverage will begin as described in the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More."

Changing or canceling coverage

You may make changes to your enrollment election during the Annual Benefits Enrollment period or if you experience certain Qualified Events during the year. For more information on making enrollment election changes, refer to the "Changing coverage" section in "Chapter 1: Eligibility, Enrollment, and More."

When coverage ends

Dental coverage for you or any enrolled dependents ends as described in the "When coverage ends" section in "Chapter 1: Eligibility, Enrollment, and More."

Cost

You must make contributions to pay for the cost of dental coverage. For more information, refer to the "Cost and funding" section in "Chapter 1: Eligibility, Enrollment, and More."

Claims administrator

The dental plan is self-insured, and Delta Dental is the claims administrator providing administrative claims services. Delta Dental is the named claims and appeals fiduciary for the dental plan and has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the dental plan and the respective coverage options.

How the Delta Dental coverage options work

Although you may use any provider you want, you'll pay less, in most cases, when you use a Delta Dental participating provider because network providers agree to accept Delta Dental's contracted network fee ("allowable fee") as the maximum charge for covered services. The two networks of participating providers are the Delta Dental PPO℠ network and the Delta Dental Premier® network. To find out if your provider participates in either of these networks, call Delta Dental at 1-877-598-5342 or visit https://www.deltadentalmn.org/wf.

Nearly two-thirds of all dental providers nationwide participate in either the Delta Dental PPO or Delta Dental Premier networks. However, providers in the Delta Dental PPO network have generally agreed to lower contracted fees than providers in the Delta Dental Premier network. If you have access to providers in both networks, you may pay less out of pocket if you receive services from a Delta PPO provider than you would if you receive them from a Delta Dental Premier network provider.

If you use a Delta Dental PPO network provider or a Delta Dental Premier network provider, you will need to identify yourself as a Delta Dental participant when scheduling an appointment. You will not need to file a claim for reimbursement because the network provider bills Delta Dental. You will be responsible for your portion of the contracted allowable fee. You will also be responsible for the full cost of any services not covered by the dental plan.

If you use an out-of-network provider, you must pay the out-of-network provider for services and then file a claim with Delta Dental. You will be reimbursed for covered services up to the applicable portion of the cost indicated in Delta Dental's table of allowance. See the "Allowable fees and benefit payments" section on page 3-6 for more information. Benefits will be paid directly to you rather than to the out-of-network provider. You will be responsible for the full cost billed by the out-of-network provider, even if that amount is greater than the Delta Dental allowed amount. For more information on claims and how to obtain a claim form, see the "Claims and appeals" section on page 3-9.

You and all of your covered dependents will receive an ID card from Delta Dental. The ID card includes a subscriber number as your primary identification. The subscriber number is a random (system-generated) member ID that you will need to present when you receive services from a Delta Dental network provider. You must submit out-of-network claims with Delta Dental and must always include your member ID. If you have questions or need additional ID cards, please call Delta Dental's customer service at 1-877-598-5342.

It is important for you to know that when an optional form of treatment is available, the Delta Dental coverage options will only cover the cost of the most appropriate, cost-effective method of treatment (as determined by Delta Dental). It is recommended that you request a pretreatment estimate to find out what will be covered before services are rendered. Please see the "Pretreatment estimate" section on this page.

Delta Dental evaluates all submitted dental procedures to determine if the procedure is a covered service under the dental plan. The dental plan includes a preset schedule of dental services that are eligible for coverage. Other services that are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the dental plan may be recommended or prescribed by your dentist. While these services may be prescribed and may be dentally necessary for you, they may not be dental services that are covered by the dental plan.

It is between you and your provider to determine the treatment or procedures that you will receive. The provisions of the Delta Dental coverage option in which you're enrolled on the date of service control what, if any, benefits are available for the services you receive.

Pretreatment estimate

A pretreatment estimate can help you make informed decisions about treatment. You should get a pretreatment estimate if your treatment is estimated to cost $300 or more. The pretreatment estimate is also recommended for orthodontia services. Your provider can use a Delta Dental claim form or a standard American Dental Association (ADA) form and check the pretreatment box. The provider should include the following:

- Preliminary findings
- Recommended corrective procedures
- Estimated charges
- Length of treatment for orthodontia claims

The pretreatment estimate should be sent to:

Delta Dental of Minnesota
PO Box 9120
Farmington Hills, MI 48333-9120

When the review is complete, Delta Dental will send a pretreatment estimate statement to you and your provider. This estimate will include an explanation of:

- Your estimated out-of-pocket expenses
- An estimate of the services your Delta Dental coverage option will cover
- What charges (if any) are estimated to exceed Delta Dental's table of allowance

The estimate can give you an idea of your portion of the cost and coverage that may be provided under your Delta Dental coverage option. However, a pretreatment estimate does not guarantee payment and does not take into consideration any previous treatment received. The pretreatment estimate is not a claim determination and is not eligible for the appeal process.

Your actual benefits will be based on treatment received, current eligibility, remaining annual maximum, and the Delta Dental coverage option provisions in effect at the time treatment is completed. If you are covered by another dental plan, your actual benefits will be affected by coordination of benefits as well. The

final decision on whether to receive services is between you and your provider. Charges that exceed the final amount covered by your dental plan option are your responsibility.

Note: Treatment must begin within 90 days of approval of the pretreatment estimate form by Delta Dental. If you or your provider do not receive a pretreatment estimate from Delta Dental within 30 days, contact Delta Dental at 1-877-598-5342.

If you elect not to use the pretreatment estimate service, Delta Dental will not review your claim until you file it. If it is determined that the service is not covered under your Delta Dental coverage option or is not the most cost-effective method of treatment (as determined by Delta Dental), no benefits will be paid unless otherwise indicated in this chapter.

What the Delta Dental coverage options cover

The dental plan offers two coverage options. Your coinsurance amount, annual benefit maximum, and orthodontia lifetime maximum differ based on the Delta Dental coverage option you've elected.

Your dental benefits and costs at a glance

Benefits are subject to the exclusions and limitations noted in this chapter and you are responsible for all charges not covered by the dental plan. All coinsurance (%) amounts are based on allowable fees and apply only after the annual deductible is met. The annual deductible and annual maximum benefit are also based on allowable fees. See the "Allowable fees and benefit payments" section on page 3-6 for more information on the allowable fees.

Benefit features	Delta Dental Standard option[1]	Delta Dental Enhanced option[1]
Annual deductible	$50 per person. Diagnostic, preventive care, and orthodontia are not subject to the deductible. For all other services, you first pay the deductible before the Standard option pays for covered services.	$50 per person. Diagnostic, preventive care, and orthodontia are not subject to the deductible. For all other services, you first pay the deductible before the Enhanced option pays for covered services.
Annual maximum benefit	$1,500 per person. Diagnostic, preventive care, and orthodontia are not applied to the annual maximum.	$2,000 per person. Diagnostic, preventive care, and orthodontia are not applied to the annual maximum.
Diagnostic and preventive care	Covered at 100%.[2]	Covered at 100%.[2]
Basic care	You pay 20% after your deductible.	You pay 10% after your deductible.
Fillings and oral surgery	You pay 20% after your deductible for most care. For composite (white) fillings on posterior teeth, you pay 30% after your deductible.	You pay 10% after your deductible for most care. For composite (white) fillings on posterior teeth, you pay 20% after your deductible.
Periodontics	You pay 20% after your deductible.	You pay 10% after your deductible.
Endodontics	You pay 20% after your deductible.	You pay 10% after your deductible.
Major restorative services	You pay 50% after your deductible.	You pay 40% after your deductible.
Dental implants	You pay 50% after your deductible.	You pay 40% after your deductible.
Prosthetics and repairs	You pay 50% after your deductible.	You pay 40% after your deductible.
Orthodontia[3]	You pay 50%. There is a $1,500 lifetime maximum benefit per person.	You pay 50%. There is a $2,000 lifetime maximum benefit per person.

1. If you choose to receive services from an out-of-network provider, the coverage levels in the table above still apply. However, the Plan will reimburse the appropriate amount based on the lesser of the treating provider's submitted charge or the table of allowances established by Delta Dental. Plan payments for out-of-network care count toward annual and lifetime maximums.
2. Diagnostic and preventive care is covered at 100% of allowable fees and is not subject to deductible for services listed in the "Diagnostic and preventive care" section on page 3-6.
3. Orthodontia lifetime benefit based on enrollment in either the Delta Dental Standard or the Enhanced coverage option at time of appliance banding. No additional benefit is payable by changing coverage option from the Standard to Enhanced option or vice versa. Benefits paid under the former Wachovia Dental Program, a component of the former Wachovia Corporation Health and Welfare Plan, will be applied when determining the lifetime maximum orthodontia benefit under the Delta Dental Standard or Enhanced coverage options. See the "Orthodontia benefits" section on page 3-7 for more information.

Frequency limits

Certain diagnostic and preventive care, basic care, and major care services covered by the Delta Dental coverage options are subject to frequency limitations, even if they are dentally necessary to treat your specific dental condition. These limits apply to services previously received, regardless of coverage or benefits issued for the service.

For the purposes of this chapter describing dental benefits and applicable frequency limits, the plan year is the same as a calendar year, beginning on January 1 and ending the following December 31.

You are responsible for paying for dental services that are not covered by the dental plan.

Allowable fees and benefit payments

Providers who participate in the Delta Dental PPO network or Delta Dental Premier network have signed a participating and membership agreement with Delta Dental. These network providers have agreed to accept Delta Dental's contracted fee as the maximum charge for covered services; this is the allowable fee for covered services received from a network provider. Participating network providers will file the claim for you and payment will be made directly to the network provider. You will be responsible for any applicable deductible and coinsurance amounts for covered services, as described in the "Your dental benefits and costs at a glance" table on page 3-5. You are also responsible for the full cost of any services not covered by the dental plan.

If you use an out-of-network provider, claim payments are based on the lesser of the treating provider's submitted charge or the table of allowances established by Delta Dental. The table of allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed out-of-network provider. When services are received from an out-of-network provider, you must file the claim, and claim payments are sent directly to you. You are responsible for any applicable deductible and coinsurance amounts for covered services, as described in the "Your dental benefits and costs at a glance" table on page 3-5. You are also responsible for all charges not covered by the dental plan. It is your obligation to pay the out-of-network provider for all services received.

Diagnostic and preventive care

Both Delta Dental coverage options cover 100% of allowable fees for the following types of preventive care services:

- Bitewing x-rays, one set of decay detecting x-rays limited to once every 12 months
- Consultation, one in a six-month period
- Comprehensive periodontal evaluation, once per plan year
- Diagnostic x-rays and lab procedures required for oral surgery
- Emergency oral exams, up to two per plan year
- Full-mouth x-rays (or panoramic x-ray with or without bitewing x-rays), once every five years
- Palliative treatment for relief of dental pain (excludes prescription medication and temporary or interim procedures)
- Periodic exams, twice in a plan year
- Periodontal maintenance procedure, up to four per plan year
- Sealants or preventive resin restorations for children under age 16 for six- and 12-year permanent molars, once per tooth per lifetime, both procedures combined
- Single-film x-rays as required for specific diagnoses
- Space maintainers for children under age 19 to replace extracted posterior primary teeth only
- Teeth cleaning, twice per plan year
- Topical fluoride applications for children under age 18, once per plan year

Basic care

The Standard option covers 80% of the allowable fees and the Enhanced option covers 90% of the allowable fees for basic care services described below (unless otherwise noted). Your coverage begins after satisfying the annual deductible for the following types of restorative care:

- Amalgam fillings, limited to once every two years per surface.
- White fillings for front teeth limited to once every two years per surface.
- Composite (white) fillings for back teeth. The Standard option covers 70% and the Enhanced option covers 80% for composite or resin fillings for back teeth. Limited to once every two years per surface.
- Crown lengthening only when Delta Dental, at its sole discretion, determines the procedure to be dentally necessary. Documentation must show insufficient tooth structure above the osseous level to perform restorative treatment. Crown lengthening is not covered for esthetic or cosmetic purposes. It is recommended that a pretreatment estimate be requested to determine if the procedure will be covered before beginning treatment.
- Endodontics, treatment of infection of the dental pulp, including root canal work, limited to once every 24 months, per tooth.
- Extractions, surgical and nonsurgical — once per tooth.
- General anesthesia or intravenous (IV) sedation, or a combination of both, in conjunction with covered complex surgical services (as determined by Delta Dental at its discretion).
- Gingivectomy or gingivoplasty on a per-tooth or per-quadrant basis, natural teeth only, limited to once every 90 days; not covered in areas where the natural tooth has been extracted or when performed in conjunction with a restoration on the same tooth.
- Composite resin or gold, porcelain, or ceramic inlays; benefit is limited to same surfaces and cost allowances for amalgams; replacement of inlays is limited to once every five years.

- Oral surgery, when performed in the provider's office.
- Periodontics (treatment of gum disease), nonsurgical periodontics to treat periodontal disease, limited to once every two years; includes scaling and root planing.
- Surgical periodontics treatment performed as necessary to treat periodontal disease, limited to natural teeth; not covered in areas where natural tooth has been extracted.

Major care

The Standard option covers 50% of allowable fees and the Enhanced option covers 60% of allowable fees for the major care services described below. Your coverage begins after satisfying the annual deductible for the following types of major care services:

- Addition of teeth to an existing partial or removable denture, to replace a fully extracted permanent adult tooth.
- Initial installation of fixed bridgework, including inlays and crowns to form supports to replace a fully extracted permanent adult tooth or teeth; no benefits are available if a benefit for partial or full dentures has been issued for that arch (upper or lower) within the past five years.
- Initial installation of removable partial or full dentures (including adjustments during the six-month period after they are installed) to replace a fully extracted permanent adult tooth or teeth, limited to once per arch (upper and lower) every five years.
- Night guards, one per lifetime.
- Onlays and crowns (gold restorations and crowns are covered as treatment to replace tooth structure lost due to decay or fracture only when teeth cannot be restored with other filling materials); replacement of crown and onlay restorations (or coverage for any other type of restoration on that tooth) is limited to once every five years.
- Relines, twice in a 12-month period per arch but not until six months after the initial placement or rebases, once in a 24-month period.
- Repairs to existing dentures, once every six months but not until six months after the initial placement.
- Replacement of an existing partial or full denture, removable denture, or fixed bridgework, provided that the existing denture or bridgework was installed at least five years before its replacement and meets one of the following conditions:
  - The existing denture or bridgework cannot be made serviceable.
  - Replacement is made necessary by the placement of an original opposing full denture or the extraction of natural permanent teeth.
  - The bridge or denture, while in the oral cavity, was damaged beyond repair by an injury sustained while covered under the Delta Dental coverage options.
- Single-tooth implant body, abutment, and crown, once every five years for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment, and implant abutment supported crown. Some adjunctive implant services may not be covered. Therefore, it is recommended that a pretreatment estimate be requested to estimate the amount of payment before beginning treatment.
- Veneers used to restore lost tooth structure as a result of tooth decay or fracture on anterior permanent teeth, once every five years per tooth. After a tooth has been restored using a veneer, no other major restoration will be covered on that tooth for five years.
- Removable, fixed, or cemented habit-breaking appliances (including adjustment and treatment of appliances), limited to one appliance per covered member.

Orthodontia benefits

The Delta Dental coverage options cover 50% of the allowable fees for eligible orthodontia expenses. Orthodontics must be performed and supervised by a licensed dentist or orthodontist who has established the need for such procedures through a complete in-person oral examination, and has developed a proper treatment plan through adequate diagnostic activities, including radiographic imaging (x-rays).

The orthodontia lifetime benefit is based on which Delta Dental coverage option you are enrolled in at the time of appliance banding. No additional benefit is payable by changing coverage option from the Standard to Enhanced option or vice versa. For example, if appliance banding occurred while enrolled in the Standard option, the total lifetime orthodontia benefit will not exceed $1,500. If you change from the Standard option to the Enhanced option and orthodontic work is in progress, any remaining benefit will be paid up to the Standard option's $1,500 maximum benefit.

If appliance banding occurred before participation in the dental plan, the lifetime maximum is based on the Delta Dental coverage option you are enrolled in when you first receive orthodontia services, unless orthodontia benefits were paid under the former Wachovia Dental Program. The total lifetime orthodontia benefits paid per person, combined with any other orthodontia benefits paid under the Wells Fargo dental plan or the former Wachovia Dental Program, cannot exceed a total of $1,500 if you're enrolled in the Standard option, or $2,000 if you're enrolled in the Enhanced option.

The Delta Dental coverage options cover the following types of orthodontia expenses:

- Preliminary studies for orthodontic programs, including x-rays, diagnostic casts, and recommended treatment schedules
- Limited, interceptive, or comprehensive orthodontia treatment plans, which include all active and retention appliances (when included in the fee); retention is not a separately covered benefit

It is recommended that you obtain a pretreatment estimate, as described under the "Pretreatment estimate" section on page 3-4, so both you and your orthodontist may receive an estimate of what your Delta Dental coverage option will cover. For more information, see the "Orthodontia claims" section on page 3-9.

What is not covered

Charges for some types of dental work will not be covered by the dental plan. These charges include:

- Accidental injury to natural teeth covered by any medical plan or medical benefit program
- Anatomical crown exposure
- Anesthesiologist services
- Antimicrobial and biologic material
- Appliances, restorations, and procedures to alter vertical dimension (increasing height of upper and lower teeth)
- Athletic mouth guards
- Bacteriologic tests
- Brush biopsy and the accession of a brush biopsy
- Case presentations
- Charges for completing claim forms or for missed appointments
- Charges for services provided other than the least costly appropriate restorative procedure as determined by Delta Dental
- Charges incurred after your dental coverage under the Health Plan ends
- Claims filed later than 12 months from the date of service when you choose an out-of-network provider
- Comfort or convenience items
- Cone beam images
- Crown lengthening, except as noted in the "Basic care" section on page 3-6
- Cytology sample collection
- Educational programs, such as dietary instruction or training for plaque control or oral hygiene
- Enamel microabrasion and odontoplasty
- Extra sets of dentures or other appliances if benefits were previously provided
- Facility charges
- Finance or late charges
- Genetic testing
- Guided tissue regeneration
- Incomplete or interim procedures
- Injury or disease covered by Workers' Compensation or other similar laws; this exclusion applies to any covered person, including the employee, a spouse or domestic partner, and dependent child
- Injury or disease incurred in connection with and while in self-employment or in the employment of someone else for wages or profit, including farming
- Office visit in which no dental procedures are performed and that is not a dental consultation
- Orthodontics not performed and supervised by a licensed dentist or orthodontist who has established the need for such procedures through a complete in-person oral examination, and has developed a proper treatment plan through adequate diagnostic activities, including radiographic imaging (x-rays).
- Pediatric partial denture, fixed
- Periodontal splinting (temporary wiring or permanently bonding teeth together)
- Prescribed medications
- Preventive resin restoration
- Provisional pontic and provisional retainer crown
- Provisional splinting (intracoronal or extracoronal)
- Pulpal regeneration
- Repair or replacement of any orthodontic appliance
- Replacement of existing dentures or bridgework, unless listed in the "Major care" section on page 3-7
- Replacement of lost or stolen prosthetic devices if benefits were previously provided
- Retreatment or additional treatment necessary to correct or relieve the result of treatment previously covered under the Delta Dental coverage options
- Services completed before the date the covered person became eligible for the coverage
- Services not indicated as covered
- Services or supplies not recommended or prescribed by a dentist, orthodontist, or oral surgeon
- Special stains applied to biopsies or surgical specimens
- Temporary anchorage devices
- Temporary procedures
- Temporomandibular joint dysfunction (TMJ)-related procedures, appliances, restorations, and diagnostic services, whether medical or dental in nature
- The portion of the cost for a service that is above the allowable fee for that service
- Therapeutic drug injections
- Treatments and appliances in connection with congenitally missing teeth
- Treatment covered by another group plan through an employer, HMO, mutual benefit association, labor union, trustee, or another similar group plan
- Treatment in excess of yearly or lifetime maximum benefit or frequency limits
- Treatment needed as a result of any intentional, self-inflicted injury

- Treatment not approved by the Council of Dental Therapeutics of the American Dental Association or treatment that is experimental in nature
- Treatment provided for cosmetic reasons
- Treatment provided while not covered under the Delta Dental coverage options
- Unilateral partial
- Viral cultures
- Work that is furnished by or payable by any civil unit or any government, if treatment is otherwise free of charge to patients

Claims and appeals

The detailed procedures that govern the filing of claims and appeals under the Delta Dental coverage options are set forth in "Appendix A: Claims and Appeals." Additional information regarding the filing of claims and appeals unique to the Delta Dental coverage options is described below.

Delta Dental is the claims administrator and the named claims and appeals fiduciary for the dental plan. Delta Dental has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the dental plan and respective coverage options.

Delta Dental network providers

If you use a Delta Dental network provider, tell your network provider that you have coverage through Delta Dental under the Wells Fargo & Company Health Plan at the time of your appointment. The network provider's office will file the claims, which must be filed with Delta Dental within 12 months of the service date.

If the claim is approved, benefit payment will be issued directly to the network provider indicating that the claim has been paid. If the claim is not approved (in whole or in part) or needs additional information, you will receive an Explanation of Benefits indicating the reason for nonpayment.

You are responsible for payment of deductibles, coinsurance, and any other payments to the network provider for services not covered by the Delta Dental coverage options. However, you are not responsible for any amounts the network provider is required to write off as a result of their contract with Delta Dental.

Out-of-network providers

If your provider is an out-of-network provider, you must file your own dental claims. Many out-of-network providers will file claims on behalf of their patients, but out-of-network providers are not required to do so. All claims must be filed with Delta Dental of Minnesota within 12 months of the date of service. It is your responsibility to ensure that claims are timely filed.

You can use a Delta Dental claim form or a standard ADA claim form available at the provider's office. You may get a claim form from Delta Dental at https://www.deltadentalmn.org/wf or you may call Delta Dental at 1-877-598-5342. Send the completed claim form to Delta Dental of Minnesota within 12 months of the date of service at the following address:

Delta Dental of Minnesota
PO Box 9120
Farmington Hills, MI 48333-9120

Providing all needed information when filing a claim can help avoid delays in processing the claim. If the claim is approved, a check is produced, along with an Explanation of Benefits, and both will be issued to you. Delta Dental does not issue payments to out-of-network providers. If the claim is not approved (in whole or in part) or needs additional information, you will receive an Explanation of Benefits indicating the reason for nonpayment.

You are responsible for paying the out-of-network provider in full.

Orthodontia claims

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of the treatment.

Treatment beginning after coverage is effective

Before services are received, the provider should submit a pretreatment estimate of total cost to Delta Dental. For more information, see the "Pretreatment estimate" section on page 3-4.

After review and approval by Delta Dental, benefits will be estimated. You and your provider will receive an Estimate of Benefits showing the approved services and the estimated benefit amount. Services must begin within 90 days of the approval date. If you or your provider do not receive an Estimate of Benefits within 30 days, contact Delta Dental at 1-877-598-5342.

When the orthodontic appliances are installed, the provider should file the claim by submitting the Estimate of Benefits with the date of placement and the provider's signature to Delta Dental. An out-of-network provider may require you to file the claim. Upon receipt, Delta Dental will verify eligibility and make payment for one-half of the predetermined benefit amount, subject to the lifetime maximum orthodontia benefit for the coverage option you were enrolled in at the time of appliance banding.

A second Estimate of Benefits will be issued at the time of payment.

After six months of ongoing treatment, the provider should file the claim for remaining benefits by submitting the second Estimate of Benefits with the provider's signature to Delta Dental. An out-of-network provider may require you to file the claim. Upon receipt, Delta Dental will verify eligibility and, if the patient is still covered under the Delta Dental coverage options, make payment for the second half of the estimated benefit amount, subject to the lifetime maximum orthodontia benefits.

Delta Dental will pay network providers directly. Delta Dental will pay you directly for services rendered by out-of-network providers. You will be responsible for paying your out-of-network provider.

Treatment in progress when coverage becomes effective

If orthodontia treatment is already in progress when you first enroll in a Delta Dental coverage option, the following information should be submitted to Delta Dental to determine if benefits are available:

- Total treatment cost, including retainers
- Description of the treatment, including procedure code
- Estimated length of active treatment (total time, not just time remaining)
- Date the appliances were installed
- Provider's signature and date

After review and approval by Delta Dental, benefits will be prorated based on the coverage option you were enrolled in at the time of appliance banding. Coverage will also be prorated based on the number of months of active treatment remaining.

Orthodontia benefits paid under the former Wachovia Dental Program will be applied to the lifetime maximum benefit under the Wells Fargo dental plan. No additional benefit is payable by changing coverage option from the Standard to Enhanced option or vice versa.

Coordination of benefits

The Delta Dental coverage options include a coordination of benefits provision called "nonduplication of benefits." This means that if you or your eligible dependents are covered by another dental plan and the Delta Dental coverage option is the secondary payer, then the Delta Dental coverage option will pay the difference of the amount it would have paid if it had been the primary plan minus the amount paid by your primary plan. For example, if the Delta Dental coverage option would have paid $400 as the primary plan, and your primary plan pays $400 or more, then the Delta Dental coverage option will pay nothing.

Delta Dental's calculation of what it would pay if Delta Dental's coverage had been primary also considers the annual maximum benefit available at the time of your claim. For example, if you have $500 left of your annual maximum benefit with Delta Dental and the primary plan paid $500 or more for a claim, the Delta Dental coverage option would pay nothing for that claim.

Also, there is no coordination of benefits between benefit options under the Health Plan. Benefits will not be paid from more than one Health Plan benefit option for the same services. For example, you cannot receive benefits under the Health Plan from both a dental plan option and a medical plan option for the same services.

The following rules determine the primary plan:

- The plan with no coordination of benefits provision is primary.
- If both plans have a coordination of benefits provision:
  - For employees and their spouses or domestic partners, the plan covering the patient as an employee (rather than a dependent) is primary.
  - For covered children, the plan of the parent whose birthday falls earlier in the year is primary.
  - For children of divorced or separated parents, plans pay in this order, unless a court decree stipulates otherwise:
    1. The plan of the parent who has custody of the child.
    2. The plan of the spouse or domestic partner of the parent who has custody of the child.
    3. The plan of the parent who does not have custody of the child.

Questions about claim determinations

If you have a question or concern about a claim processed by Delta Dental, you may call Delta Dental's member services. In the event your claim is denied (in whole or in part), you may also file a formal written appeal under the terms of the Health Plan. Please note that if you call Delta Dental, your call will not be considered a formal appeal under the terms of the Health Plan. A formal written appeal must be filed with Delta Dental within 180 days of the date your claim is denied regardless of any verbal discussions that have occurred regarding your claim.

For member services information, see the "Contacts" section on page 3-2.

Complete information on appeals is provided in "Appendix A: Claims and Appeals."

Right of recovery

The dental benefit option is part of the Wells Fargo & Company Health Plan (the Health Plan). The Health Plan has the right to recover benefits it has paid on your or your dependent's behalf that were: (a) made in error, (b) due to a mistake in fact, (c) paid before you meet the annual deductible, (d) caused by the act or omission of another party, (e) covered by no-fault or employers' liability laws, (f) available or required to be furnished by or through national or state governments or their agencies, or (g) the result of injury sustained on the property of a third party. Benefits paid because you, your dependent, or provider misrepresented facts are also subject to recovery. Right of recovery may be pursued by claims reprocessing, by notification of overpayment, or through the subrogation process. In addition, the rights of reimbursement and subrogation apply whether or not you or your dependent have been fully compensated for losses or damages by any recovery of payments, and the Health Plan will be entitled to immediately collect the present value of subrogation rights from said payments.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, medical payments coverage, other substitute coverage, or any other right of recovery, whether based on tort, contract, equity, or any other theory of recovery. The Health Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, noneconomic damages, and general damages, or a combination of the above, only. The right of reimbursement is binding upon you, your legal representative, your heirs, next of kin, and any trustee or legal representative of your heirs or next of kin in the event of your death. Any amounts you receive from such a recovery must be held in trust for the Health Plan's benefit to the extent of subrogation or reimbursement claims. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made from such constructive trust until the Health Plan's subrogation and reimbursement interests are fully satisfied. You agree to cooperate fully in every effort by the Health Plan to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to inform the Health Plan in writing within 30 days of giving notice to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents also agree to provide written notice to the Health Plan prior to receipt of any recovery or within 5 days if no notice was given prior to your receipt of the funds.

Recovery of overpayments

If the Health Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Health Plan has the right to recover the excess amount paid. Both the claims administrator and plan administrator have the right to conduct recovery actions on behalf of the Health Plan. This may be accomplished by any combination of the following:

- Reprocessing of the claim
- Requiring that the overpayment be returned when requested by the claims administrator or the plan administrator, on behalf of the Health Plan
- Reducing or offsetting a future benefit payment for you or your dependent by the amount of the overpayment

Recovery of advanced payments

If the Health Plan provides an advancement of benefits to you or your dependent before you meet the applicable annual deductible, or the applicable annual out-of-pocket maximum, the Health Plan has the right to recover advanced payment of benefits. Both the plan administrator and the applicable claims administrator have the right to conduct recovery actions on behalf of the Health Plan. The claims administrator or the plan administrator, on behalf of the Health Plan, may send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Health Plan has the right to recover benefits it has advanced by pursuing both of the following:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Health Plan
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Health Plan

Reimbursement policy

The right of reimbursement means you must repay the Health Plan at the time you make any recovery. Recovery means all amounts received by you from any persons, organizations, or insurers by way of settlement, verdict, judgment, award, or otherwise, on account of injury or condition. The Health Plan will not cover the value of the services to treat such an injury or condition, or the treatment of such an injury or condition. However, the Health Plan may advance payment to you for these dental expenses if you, or any person claiming through or on your behalf, agree to do both of the following:

- Grant to the Health Plan a first priority lien against any proceeds of any settlement, verdict, or insurance proceeds received by you or on your behalf as a result of the third party's actions and are to be repaid to the Health Plan before you receive any recovery for your damages
- Assign to the Health Plan any benefits you may receive under any automobile policy or other insurance coverage, to the full extent of the Health Plan's claim for reimbursement

You must sign and deliver to the claims administrator or the plan administrator on behalf of the Health Plan, as directed, any documents needed to protect the Health Plan's lien or to affect the assignment of your benefits. You must also agree not to take any action that is inconsistent with the Health Plan's right to reimbursement. Reimbursement will be made regardless of whether you are fully compensated, or "made whole," by the settlement, verdict, judgment, award, or insurance proceeds and regardless of whether costs are allocated to "dental expenses." The Health Plan will not be responsible for bearing the cost of any legal fees you incur as a result of any action you take against the third party. If, after recovery of any payments, you receive services or incur expenses on account of such injury or condition, you may be required to pay for such services or expenses. The total of all reimbursement and payments will not exceed your recovery.

If you refuse to fully reimburse the Health Plan after receipt of a settlement, verdict, judgment, award, or insurance proceeds, the Health Plan may not pay for any future expenses, whether anticipated or unanticipated, relating to your injury or condition. In addition, the Health Plan may seek legal action against you to recover paid dental benefits related to your injury or condition. In addition, the Health Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent covered expenses are paid by the Health Plan.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Subrogation

Under the reimbursement method of subrogation, you reimburse the Health Plan any money you receive through a settlement, verdict, judgment or award, or insurance proceeds. At its sole discretion, the Health Plan also has the option of directly asserting its rights against the third party through subrogation. This means that the Health Plan is subrogated to all of your rights against any third party who is liable for your injury or condition. The Health Plan may also be subrogated for the payment for the treatment of your injury or condition to the extent of the value of the dental benefits provided to you by the Health Plan. The Health Plan may make a claim in your name or the Health Plan's name against any persons, organizations, or insurers on account of such injury or condition. The Health Plan may assert this right independently of you.

You are obligated to cooperate with the Health Plan and its agents in order to protect the Health Plan's subrogation rights. Cooperation means providing the Health Plan or its agents with any relevant information as requested, signing and delivering such documents as the Health Plan or its agents request to secure the Health Plan's subrogation claim, and obtaining the Health Plan's consent or its agents' consent before releasing any third party from liability for payment of your dental expenses.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Health Plan. Any costs incurred by the Health Plan in matters related to subrogation may be paid for by the Health Plan. The costs of legal representation you incur will be your responsibility.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Interpretation

In the event that any claim is made that any part of this "Right of recovery" section is ambiguous, or questions arise concerning the meaning of the intent of any of its terms, the plan administrator or its designees shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this "Right of recovery" section. The Health Plan's rights reflected in this "Right of recovery" section are in addition to and not in lieu of any similar rights the Health Plan may have in connection with the medical benefits described in "Chapter 2: Medical Plans" or the vision benefits described in "Chapter 4: Vision Plan."

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to you or made on behalf of you to any provider) from the Health Plan, you agree that any court proceeding with respect to this "Right of recovery" section may be brought in any court of competent jurisdiction as the Health Plan or its designee may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond to you by reason of your present or future domicile.

Chapter 4: Vision Plan

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Contacts

Information about benefits, claims, appeals, providers, covered services, or forms — contact the claims administrator	Vision Service Plan (VSP) 1-877-861-8352 wf.vspforme.com Member ID is your Employee ID preceded by zeros to equal an 11-digit number.
Information about vision benefit provisions	HR Services & Support site
Information about enrollment	Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.
Information about premiums	HR Services & Support site

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix A: Claims and Appeals," "Appendix B: Important Notifications and Disclosures," "Appendix D: Leaves of Absence and Your Benefits," and "Appendix E: Continuing Coverage Under COBRA" — constitutes the Summary Plan Description (SPD) for the vision benefit option available under the Wells Fargo & Company Health Plan (the Health Plan). The vision benefit option is also referred to as the vision plan.

The basics

General information

The Vision Service Plan (VSP) is the vision benefit option under the Wells Fargo & Company Health Plan. The Wells Fargo & Company Health Plan is a group health plan and is classified as a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

You must be enrolled in the vision plan on the date of service to receive benefits.

The vision plan covers periodic professional eye exams for you and your covered dependents. The exam includes an analysis of the visual functions, and you may receive a prescription for corrective lenses if indicated.

If you are enrolled in the vision plan, you agree to authorize your provider to give VSP access to required information about your care. Your failure to provide this authorization or any requested information may result in denial of your claim. VSP may require this information to process claims, to conduct quality improvement and utilization review activities, or for other health plan activities, as permitted by law. VSP may release the information, if you authorize VSP to do so, or if state or federal law permits or allows release without your authorization.

Who's eligible

Regular and fixed term Wells Fargo employees are eligible to enroll in the vision plan. If you are enrolled as an eligible employee, you may also cover your eligible dependents including your spouse or domestic partner. Interns and flexible employees and their dependents are not eligible to enroll in the vision plan. Detailed eligibility requirements are described in the "Who's eligible to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

You may not be covered under the vision plan as both an employee and spouse or domestic partner of another employee, or an employee and a dependent child of another employee at the same time. Also, an eligible dependent can only be covered under one employee.

How to enroll and when coverage begins

Refer to the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment. After you have enrolled, coverage will begin as described in the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More."

Changing or canceling coverage

You may make changes to your enrollment election during the Annual Benefits Enrollment period or if you experience certain Qualified Events during the year. For more information on making enrollment election changes, refer to the "Changing coverage" section in "Chapter 1: Eligibility, Enrollment, and More."

When coverage ends

Vision coverage for you or any enrolled dependents ends as described in the "When coverage ends" section in "Chapter 1: Eligibility, Enrollment, and More."

Cost

You must make contributions to pay for the cost of vision coverage. For more information, refer to the "Cost and funding" section in "Chapter 1: Eligibility, Enrollment, and More."

Claims administrator

The vision plan is self-insured, and VSP is the claims administrator providing administrative claims services. VSP is the named claims and appeals fiduciary for the vision plan and has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the vision plan.

How the vision plan works

The vision plan uses VSP's Choice Network, which contracts with a nationwide network of private practice optometrists and ophthalmologists, many of whom are located in retail settings. You will generally pay less out of pocket if you use a network provider rather than an out-of-network provider.

You will receive an ID card from VSP. You may also print a personalized ID card from wf.vspforme.com.

It's between you and your provider to determine the treatment or procedures you'll receive. The provisions of the vision plan control what, if any, benefits are available for the services you receive.

Using a network provider

For information about network providers, check wf.vspforme.com or call 1-877-861-8352. Network providers are available in all 50 states, the District of Columbia, and Puerto Rico.

If you use a network provider, identify yourself as a VSP participant when scheduling an appointment. You will pay a copay for covered exams and eyewear that fall within the vision plan's allowance. You will not need to file a claim for reimbursement because the provider bills VSP. Network benefits will be provided as shown in the "Your vision plan benefits and costs at a glance" section on page 4-5, subject to the provisions stated within this chapter of the Benefits Book.

It's important to note that not all listed services are available from some participating retail chains. For information about participating retail chains and what services are available, contact VSP.

Using an out-of-network provider

If you use an out-of-network provider, you must pay the entire cost for vision services and supplies, and then you must file a claim for reimbursement with VSP within 12 months of the date of service. Out-of-network benefits will be provided as shown in the "Your vision plan benefits and costs at a glance" table belowon page page 4-5, subject to the provisions stated within this chapter of the Benefits Book. For information on filing claims, see the "Claims and appeals" section on page 4-8 in this chapter.

Your vision plan benefits and costs at a glance

Benefits will be provided as shown in the following table. Services and supplies listed here are subject to the criteria, exclusions, and limitations noted within this chapter. Benefits are only provided once per calendar year, network and out-of-network benefits combined. A calendar year is the period from January 1 through the following December 31.

Plan features	Network benefits*	Out-of-network benefits
Eye exams (limited to once every calendar year)	You pay a $10 copy.	Vision plan pays up to $45 after you pay a $10 copy.
Lenses (limited to once every calendar year) Including polycarbonate lenses for enrolled dependent children	You pay a $15 copay only once per calendar year, for lenses or frames, whether purchased together or separately.**	You pay a $15 copay only once per calendar year, for lenses or frames, whether purchased together or separately.** After you have paid your copay:
• **Single vision**		Vision plan pays up to $45 for single vision lenses.
• **Bifocal**		Vision plan pays up to $65 for bifocal lenses.
• **Trifocal**		Vision plan pays up to $85 for trifocal lenses.
• **Lenticular**		Vision plan pays up to $125 for lenticular lenses.
Frames (limited to once every calendar year)	Vision plan pays $175 toward a frame of your choice after you pay a $15 copay. You pay the $15 copay only once per calendar year, for lenses or frames, whether purchased together or separately.**	Vision plan pays up to $50 toward a frame of your choice after you pay a $15 copay. You pay the $15 copay only once per calendar year, for lenses or frames, whether purchased together or separately.**
Contact lenses (limited to once every calendar year, in lieu of glasses)		
• **Elective**	Vision plan pays $175 toward contact lenses. (Includes evaluation and fitting services.)	Vision plan pays up to $175. (Includes evaluation and fitting services.)
• **Medically necessary**	You pay a $15 copay.	Vision plan pays up to $190 after you pay a $15 copay.
Diabetic Eyecare Plus Program Services related to diabetic eye disease, glaucoma, or age-related macular degeneration (AMD). Includes retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Your VSP doctor can provide you with details; also see the "Diabetic Eyecare Plus Program" section on page 4-7 for more information.		
• **Eye examination**	You pay a $20 copay.	Not covered.
• **Special ophthalmological services**	Covered in full.	Not covered.

* Not all listed services are available from some participating retail chains. Contact VSP for details.

** If you purchase both frames and lenses when you buy new glasses, you pay one $15 copay. However, if you only get new frames or only get new lenses, you still pay one $15 copay. The $15 copay for frames and lenses is limited to once every calendar year whether you purchase them separately or combined.

You may also purchase extras, such as tinted or coated lenses that are not covered under the vision plan, or frames that exceed the vision plan's allowance, at a discounted price when you use a network provider. However, these discounts are not part of the vision plan benefits and are subject to change without notice. Contact VSP or a VSP network provider about available discounts.

What the vision plan covers

Eye exams

A comprehensive eye exam is covered once every calendar year. Exams performed by a VSP network provider are covered at 100% after you pay a $10 copay, regardless of the number of tests needed to assess the health of the patient's eyes. However, a contact lens evaluation may require an additional charge. If an additional charge is required, you will be responsible for the full cost of the additional charges.

A comprehensive eye exam generally includes:

- Case history
- Evaluation of the visual system
  - External and internal exam, to include direct ophthalmoscopy, indirect ophthalmoscopy, or both
  - Neurological integrity, including pupillary reflexes and extraocular muscle assessment (versions)
  - Biomicroscopy
  - Visual field screening
  - Tonometry
  - Glaucoma, blind spots, and other retinal abnormalities
- Refractive status evaluation procedures
- Binocular function tests
- Diagnosis and treatment plan

Refer to the "Your vision plan benefits and costs at a glance" table on page 4-5 for out-of-network benefits, and to the "What is not covered" section starting on page 4-7 for exclusions.

Lenses

Expenses for the necessary eyewear and professional services from a VSP network provider connected with ordering, fitting, and adjusting corrective lenses are covered as described below:

- Spectacle lenses, including single vision, lined bifocal, lined trifocal, or other more complex and expensive lenses, necessary for the patient's visual welfare after you pay a $15 copay (see the "Your vision plan benefits and costs at a glance" table on page 4-5). You pay the full cost of additional options selected for lenses (for example, tinted or photochromic lenses, blended bifocals, high-index plastic, or antireflective coating).
- Elective contact lenses in lieu of spectacle lenses and frames will be covered up to the vision plan's allowance of $175. The allowance will be applied toward the cost of the contact lens exam (evaluation and fitting) and the contacts. You must pay any additional costs exceeding the vision plan's allowance. The benefit will be paid only once every calendar year, even if you don't use the entire allowance. Therefore, VSP recommends that when ordering disposable contacts, you order a supply that is sufficient to use the entire vision plan allowance.
- Medically necessary contact lenses are fully covered after you pay a $15 copay when received from a VSP network provider for any of the following conditions:
  - Extreme visual acuity problems that cannot be corrected with spectacle lenses
  - Certain conditions of anisometropia
  - Keratoconus

Refer to the "Your vision plan benefits and costs at a glance" table on page 4-5 for out-of-network benefits, and to the "What is not covered" section starting on page 4-7 for exclusions.

Frames

The frame allowance is $175 after you pay a $15 copay (see the "Your vision plan benefits and costs at a glance" table on page 4-5) when you receive frames from a VSP network provider. You must pay any additional cost if you select a frame that exceeds the vision plan allowance. When using a VSP network provider, you may ask to see frames that would be fully paid by the vision plan allowance.

Refer to the "Your vision plan benefits and costs at a glance" table on page 4-5 for out-of-network benefits, and to the "What is not covered" section starting on page 4-7 for exclusions.

Low vision services

The low vision benefit provides special aid for people who have severe visual problems and may be referred to as "partially sighted." Low vision services and associated eyewear are subject to certain limitations. Therefore, before receiving services, contact VSP for more information to ensure that the services you need are covered under the vision plan.

You must pay 25% of the cost of any approved low vision program. This benefit has a maximum of $1,000 (excluding copays) every two calendar years. The maximum includes supplementary testing.

Refer to the "What is not covered" section starting on page 4-7.

Diabetic Eyecare Plus Program

The Diabetic Eyecare Plus Program (DEP Plus) provides coverage of additional eyecare services specifically for covered employees and their covered dependents with diabetic eye disease, glaucoma, or age-related macular degeneration when covered services are received from a VSP network provider. A current list of these procedures will be made available to you upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service. Plan benefits under this program are available to those diagnosed with type 1 or type 2 diabetes or specific ophthalmological conditions.

Examples of symptoms that may result in your seeking services under DEP Plus may include, but are not limited to:

- Blurry vision
- Trouble focusing
- Transient loss of vision
- "Floating" spots

Examples of conditions that may require management under DEP Plus may include, but are not limited to:

- Diabetic retinopathy
- Rubeosis
- Diabetic macular edema

Refer to the "Your vision plan benefits and costs at a glance" table on page 4-5 for information about what you will pay and to the "What is not covered" section starting on this page for exclusions.

Service frequency

Exams, eyeglass lenses or contact lenses, and eyeglass frames are covered once every calendar year, network and out-of-network combined. Therefore, if you use disposable contact lenses, you should purchase a supply that is sufficient to use the entire vision plan allowance. You may not receive benefits for both eyeglasses and contact lenses in the same calendar year.

A calendar year is the period January 1 through the following December 31.

Discounts

Discounts may be available when you use a VSP network provider for services not covered by the vision plan. These discounts are not part of the vision plan benefits and are subject to change without notice. Contact VSP or a VSP network provider about available discounts for the following:

- Frames that exceed the vision plan allowance
- Options such as tinted or coated lenses
- Additional pairs of prescription or nonprescription glasses and sunglasses
- Laser vision surgery

What is not covered

The vision plan does not cover charges for some types of vision care, including:

- Any additional pair of glasses or sunglasses
- Any eye exam required as a condition of employment
- Any injury or illness when covered under any Workers' Compensation or similar law, or that is work-related
- Charges for services or materials that exceed vision plan benefit allowances
- Charges incurred after the Health Plan ends or your vision coverage under the Health Plan ends
- Claims filed later than 12 months from the date of service when you choose an out-of-network provider
- Cosmetic options, including:
  - Antireflective coating
  - Blended lenses
  - Color coating
  - Cosmetic lenses (plano — prescription strength of less than ±0.50)
  - Laminated lenses
  - Mirror coating
  - Optional cosmetic processes
  - Oversize lenses
  - Photochromic or tinted lenses other than Pink #1 or #2
  - Progressive multifocal lenses
  - Scratch coating
  - UV (ultraviolet)-protected lenses
- Frame charges in excess of the vision plan allowance
- Laser vision surgery
- Local, state, and/or federal taxes, except where VSP is required by law to pay
- Medical or surgical treatment of the eyes
- Orthoptics or vision training and any associated supplemental testing
- Polycarbonate lenses for adults
- Replacement of lenses and frames furnished under the vision plan that are lost or broken
- Services or materials not indicated as covered
- Surgery of any type, and any pre- or post-operative services
- Two pairs of eyeglasses instead of bifocals

In addition, the following are not covered under DEP Plus:

- Services and materials not specifically included as plan benefits
- Frames, lenses, contact lenses, or any other ophthalmic materials
- Treatment for any pathological conditions
- Insulin or any medications or supplies of any type

Coordination of benefits

The vision plan is always primary over other vision plans for the covered employee.

When an employee and their covered spouse or domestic partner are employees of different companies and both have vision coverage that is administered by VSP, coordination of benefits is available.

If you or a covered dependent is covered under two vision plans, notify the provider at the time you are making an appointment and identify the two plans that cover you or your dependents. The provider will coordinate the coverage between the plans.

For further details on coordination of benefits, contact VSP.

Claims and appeals

The detailed procedures that govern the filing of claims and appeals are set forth in "Appendix A: Claims and Appeals." Additional information regarding the filing of claims and appeals unique to the vision plan is described below.

VSP is the claims administrator and the named claims and appeals fiduciary for the vision plan. VSP has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the vision plan.

Filing a claim with a network provider

The VSP network provider will contact VSP to obtain information concerning your benefits and eligibility, provided that you have identified yourself as a VSP participant before you receive services. There is no paperwork for you to complete; the VSP network provider will file claims with VSP. Network providers must file claims with VSP within six months of the date of service. VSP will pay your network provider for covered services and supplies. You are responsible for payment of all charges not covered by the vision plan. However, you are not responsible for any amounts the network provider is required to write off as a result of their contract with VSP.

Filing a claim with an out-of-network provider

You will pay the full cost of the exam and any eyeglasses or contact lenses selected, and you must file a claim for reimbursement with VSP within 12 months of the date of service.

You must file the claim using VSP's claim form. For a copy of the claim form, visit wf.vspforme.com or call 1-877-861-8352.

File the claim form, along with the itemized receipt, within 12 months of the date of service to:

VSP
PO Box 385018
Birmingham, AL 35238

VSP will reimburse you for out-of-pocket costs, up to the amounts stated in the "Your vision plan benefits and costs at a glance" table on page 4-5, provided that you were covered at the time services were received. You are responsible for all charges not covered or reimbursed by VSP.

More information on claims is provided in "Appendix A: Claims and Appeals."

Claim denials and appeals

If you have a question or concern about a claim processed by VSP, you may call VSP at 1-877-861-8352. In the event that your claim is denied (in whole or in part), you may also file a formal written appeal under the terms of the Health Plan. Please note that if you call VSP, your call will not be considered a formal appeal under the terms of the Health Plan. A formal written appeal must be filed with VSP within 180 days of the date your claim is denied regardless of any verbal discussions that have occurred regarding your claim.

Complete information on appeals is provided in "Appendix A: Claims and Appeals."

Right of recovery

The vision benefit option is part of the Wells Fargo & Company Health Plan (the Health Plan). The Health Plan has the right to recover benefits it has paid on your or your dependent's behalf that were: (a) made in error, (b) due to a mistake in fact, (c) caused by the act or omission of another party, (d) covered by no-fault or employers' liability laws, (e) available or required to be furnished by or through national or state governments or their agencies, or (f) the result of injury sustained on the property of a third party. Benefits paid because you, your dependent, or provider misrepresented facts are also subject to recovery. Right of recovery may be pursued by claims reprocessing, by notification of overpayment, or through the subrogation process. In addition, the rights of reimbursement and subrogation apply whether or not you or your dependent have been fully compensated for losses or damages by any recovery of payments, and the Health Plan will be entitled to immediately collect the present value of subrogation rights from said payments.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, medical payments coverage, other substitute coverage, or any other right of recovery, whether based on tort, contract, equity, or any other theory of recovery. The Health Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, noneconomic damages, and general damages, or a combination of the above, only. The right of reimbursement is binding upon you, your legal representative, your heirs, next of kin, and any trustee or legal representative of your heirs or next of kin in the event of your death. Any amounts you receive from such a recovery must be held in trust for the Health Plan's benefit to the extent of subrogation or reimbursement claims. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made from such constructive trust until the Health Plan's subrogation and reimbursement interests are fully satisfied. You agree to cooperate fully in every effort by the Health Plan to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to inform the Health Plan in writing within 30 days of giving notice to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents also agree to provide written notice to the Health Plan prior to receipt of any recovery or within 5 days if no notice was given prior to your receipt of the funds.

Recovery of overpayments

If the Health Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Health Plan has the right to recover the excess amount paid. Both the claims administrator and plan administrator have the right to conduct recovery actions on behalf of the Health Plan. This may be accomplished by any combination of the following:

- Reprocessing of the claim
- Requiring that the overpayment be returned when requested by the claims administrator or the plan administrator, on behalf of the Health Plan
- Reducing or offsetting a future benefit payment for you or your dependent by the amount of the overpayment

Recovery of advanced payments

If the Health Plan provides an advancement of benefits to you or your dependent, the Health Plan has the right to recover advanced payment of benefits. Both the plan administrator and the applicable claims administrator have the right to conduct recovery actions on behalf of the Health Plan. The claims administrator or the plan administrator, on behalf of the Health Plan, may send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Health Plan has the right to recover benefits it has advanced by pursuing both of the following:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Health Plan
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Health Plan

Reimbursement policy

The right of reimbursement means you must repay the Health Plan at the time you make any recovery. Recovery means all amounts received by you from any persons, organizations, or insurers by way of settlement, verdict, judgment, award, or otherwise, on account of injury or condition. The Health Plan will not cover the value of the services to treat such an injury or condition, or the treatment of such an injury or condition. However, the Health Plan may advance payment to you for these vision expenses if you, or any person claiming through or on your behalf, agree to do both of the following:

- Grant to the Health Plan a first priority lien against any proceeds of any settlement, verdict, or insurance proceeds received by you or on your behalf as a result of the third party's actions and are to be repaid to the Health Plan before you receive any recovery for your damages.
- Assign to the Health Plan any benefits you may receive under any automobile policy or other insurance coverage, to the full extent of the Health Plan's claim for reimbursement.

You must sign and deliver to the claims administrator or the plan administrator on behalf of the Health Plan, as directed, any documents needed to protect the Health Plan's lien or to affect the assignment of your benefits. You must also agree not to take any action that is inconsistent with the Health Plan's right to reimbursement. Reimbursement will be made regardless of whether you are fully compensated, or "made whole" by the settlement, verdict, judgment, award, or insurance proceeds, and regardless of whether costs are allocated to "vision expenses." The Health Plan will not be responsible for bearing the cost of any legal fees you incur as a result of any action you take against the third party. If, after recovery of any payments, you receive services or incur expenses on account of such injury or condition, you may be required to pay for such services or expenses. The total of all reimbursement and payments will not exceed your recovery.

If you refuse to fully reimburse the Health Plan after receipt of a settlement, verdict, judgment, award, or insurance proceeds, the Health Plan may not pay for any future expenses, whether anticipated or unanticipated, relating to your injury or condition. In addition, the Health Plan may seek legal action against you to recover paid vision benefits related to your injury or condition. In addition, the Health Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent covered expenses are paid by the Health Plan.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Subrogation

Under the reimbursement method of subrogation, you reimburse the Health Plan any money you receive through a settlement, verdict, judgment, award, or insurance proceeds. At its sole discretion, the Health Plan also has the option of directly asserting its rights against the third party through subrogation. This means that the Health Plan is subrogated to all of your rights against any third party who is liable for your injury or condition. The Health Plan may also be subrogated for the payment for the treatment of your injury or condition to the extent of the value of the vision benefits provided to you by the Health Plan. The Health Plan may make a claim in your name or the Health Plan's name against any persons, organizations, or insurers on account of such injury or condition. The Health Plan may assert this right independently of you.

You are obligated to cooperate with the Health Plan and its agents in order to protect the Health Plan's subrogation rights. Cooperation means providing the Health Plan or its agents with any relevant information as requested, signing and delivering such documents as the Health Plan or its agents request to secure the Health Plan's subrogation claim, and obtaining the Health Plan's consent or its agents' consent before releasing any third party from liability for payment of your vision expenses. If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Health Plan. Any costs incurred by the Health Plan in matters related to subrogation may be paid for by the Health Plan. The costs of legal representation you incur will be your responsibility.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Interpretation

In the event that any claim is made that any part of this "Right of recovery" section is ambiguous, or questions arise concerning the meaning of the intent of any of its terms, the plan administrator or its designee shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this "Right of recovery" section. The Health Plan's rights reflected in this "Right of recovery" section are in addition to and not in lieu of any similar rights the Health Plan may have in connection with the medical benefits described in "Chapter 2: Medical Plans" or the dental benefits described in "Chapter 3: Dental Plan."

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to you or made on behalf of you to any provider) from the Health Plan, you agree that any court proceeding with respect to this "Right of recovery" section may be brought in any court of competent jurisdiction as the Health Plan or its designee may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond to you by reason of your present or future domicile.

Chapter 5: Health Care Flexible Spending Account Plan

(Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)

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Contacts

Information about the Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account	HealthEquity 1-877-924-3967 HR Services & Support site
To fax claim forms toll-free	1-877-353-9236
To file claims online, view account information and access account activity and status, or find forms	https://participant.wageworks.com Access from HR Services & Support site.
Information about enrollment	Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix A: Claims and Appeals," "Appendix B: Important Notifications and Disclosures," "Appendix D: Leaves of Absence and Your Benefits," and "Appendix E: Continuing Coverage Under COBRA" — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Health Care Flexible Spending Account Plan (the Health Care FSA Plan). The Health Care FSA Plan is an employee benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The basics

Introduction

The Health Care FSA Plan is sponsored by Wells Fargo & Company and is administered by HealthEquity. The Health Care FSA Plan includes two FSA options — the Full-Purpose Health Care Flexible Spending Account (Full-Purpose Health Care FSA) and the Limited Dental/Vision Flexible Spending Account (Limited Dental/Vision FSA), as described in this chapter. You can elect one of the two options for the applicable plan year. Each allows you to set money aside on a before-tax basis to pay for eligible expenses not reimbursed by another source. **It is important to note that the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA vary in the types of expenses that can be reimbursed.** Your decision to participate in these voluntary accounts should be based on your needs and personal situation. It is important that you understand the advantages and limitations of the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA before you decide whether to participate.

You may contribute from $130 to $2,750 annually to either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, subject to limitations imposed by applicable law and IRS guidance.

The information provided in this chapter is not intended to provide tax advice for any individual's specific situation. If you have any questions regarding the tax implications of your specific situation — including questions about whether taking health care deductions on your tax returns or enrolling in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA is more favorable to you — please consult a tax advisor.

Any balance remaining in your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA after eligible expenses have been submitted and reimbursed by the filing deadline will be forfeited and cannot be rolled over or paid out to you. For more information on the claims filing deadline, see the "Claims filing time frame" section on page 5-16.

Claims administrator

HealthEquity is the claims administrator and processes requests for reimbursement from the applicable Full-Purpose Health Care FSA and the Limited Dental/Vision FSA. HealthEquity is the named claims and appeals fiduciary and has the sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the Health Care FSA Plan and respective FSA options.

Reimbursements

Each FSA is a bookkeeping account established to keep track of your contributions and reimbursements. Except as required by law, amounts credited to the applicable FSA remain the property of Wells Fargo & Company until reimbursed to the participant. Although this chapter refers to payroll deductions and contributions that are set aside, these deductions and contributions reflect pay reductions that you authorize with the understanding that all such deductions and contributions are held as, and reimbursements paid from, Wells Fargo & Company's general assets. No specific assets are set aside or otherwise segregated from Wells Fargo & Company's general assets for reimbursements.

Health Care FSA Plan options

If you are a regular or fixed term employee, you may elect the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA if you are enrolled in any Wells Fargo offered medical plan or if you have waived medical coverage. Advantages and limitations of both options are indicated below.

The Full-Purpose Health Care FSA

The Full-Purpose Health Care FSA allows you to be reimbursed for eligible medical, dental, and vision expenses (for example, copayments, orthodontia, eyeglasses, and prescribed medications for you or your eligible dependents) that are not reimbursed by another source. For more information about eligible expenses under the Full-Purpose Health Care FSA, go to https://participant.wageworks.com.

- **Important consequences to your health savings account (HSA) eligibility if you enroll in a high deductible health plan.** If you enroll in a high deductible health plan and elect a Full-Purpose Health Care FSA, neither you nor Wells Fargo will be able to contribute to your health savings account (HSA) (including employer contributions, if otherwise eligible, and earned health and wellness dollars). You may want to consider enrolling in the Limited Dental/Vision FSA rather than the Full-Purpose Health Care FSA to allow you and Wells Fargo to contribute to your HSA (including employer contributions, if eligible, and any earned health and wellness dollars).

- **Important information about HSA eligibility due to interaction of Full-Purpose Health Care FSA grace period**, which runs from January 1 through March 15. If you are currently enrolled in the Full-Purpose Health Care FSA but decide to enroll in a high-deductible health plan next year, you'll need to use all the dollars remaining in your Full-Purpose Health Care FSA by December 31 of the current year to contribute to an HSA beginning January 1 of the next year. Although you can be covered under a high-deductible health plan beginning January 1 of that next year, neither you nor Wells Fargo can make contributions toward your HSA (including employer HSA contributions, if eligible, and earned health and wellness dollars) until April of that year if you have dollars remaining in your Full-Purpose Health Care FSA on December 31, per IRS requirements. In addition, any medical expenses that you, your spouse, or other eligible tax dependents incur between January 1 and March 31 of the following year may not be considered qualified medical expenses eligible for reimbursement from your HSA, even if you're enrolled in one of the high-deductible health plans: the Higher Use Plan with HSA (including Out of Area), the Lower Use Plan with HSA (including Out of Area), the Narrow Network Plan with HSA, or an HDHP – Kaiser medical plan.
  - It is your responsibility to manage your balance and allow ample time for all transactions (including Card transactions, Card Use Verification Forms, and claims and expense documentation) to clear before December 31. For example, a card swipe on December 31 may not clear until January of the following year. You may also want to refrain from submitting your card number on invoices during the last week of December as some providers may not process it until early the next year. Keep in mind that reimbursement requests can be used to offset outstanding Card use verifications, so make sure all Card Use Verification Forms are submitted in a timely manner.

Note: The information in this section regarding HSA contributions is not part of the Health Care FSA Plan Summary Plan Description and is provided for informational purposes only. HSAs are individually owned accounts and not subject to ERISA.

The Limited Dental/Vision FSA

The Limited Dental/Vision FSA allows you to be reimbursed for only eligible dental or vision expenses that are not reimbursed by another source. **Medical and prescription drug expenses are not eligible for reimbursement under the Limited Dental/Vision FSA.** For more information about eligible expenses under the Limited Dental/Vision FSA, go to https://participant.wageworks.com.

- **Important information about health savings account (HSA) eligibility if you have a remaining balance in a Limited Dental/Vision FSA during the grace period, which runs from January 1 through March 15.** If you are currently enrolled in the Limited Dental/Vision FSA, have a remaining balance as of December 31 in your Limited Dental/Vision FSA, and continue your enrollment in one of the high-deductible health plans next year, you may make contributions to your HSA for the new year starting in January of that year. There is no delay in making HSA contributions because you have a remaining balance in the Limited Dental/Vision FSA.

Note: The information in this section regarding HSA contributions is not part of the Health Care FSA Plan Summary Plan Description and is provided for informational purposes only. HSAs are individually owned accounts and are not subject to ERISA.

Who's eligible

You are eligible to enroll in the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA if you are a regular or fixed term employee as described in "Chapter 1: Eligibility, Enrollment, and More." Interns and flexible employees are not eligible to enroll in an FSA.

Some rules to know

Your contributions to, and reimbursements from, the Full-Purpose Health Care FSA or Limited Dental/Vision FSA are designed to qualify for favorable tax treatment by the IRS. In exchange for these potential tax advantages, the IRS imposes strict rules about how you may use your FSA. Before enrolling, consider the rules described below and the rest of the information in this chapter. Please note the information provided in this chapter is not intended to provide tax advice for any individual's specific situation. If you have any questions regarding the tax implications surrounding your specific situation, please consult with a tax advisor.

Note: For the purposes of the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA, the plan year is the same as a calendar year, beginning on January 1 and ending the following December 31.

Full-Purpose Health Care FSA rules

In addition to the information noted below, refer to the "Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA" section starting on page 5-5, the "Using the Card with the Full-Purpose Health Care FSA" section starting on page 5-11, and "The Full-Purpose Health Care FSA" section on page 5-3 for other applicable rules.

- When you enroll in the Full-Purpose Health Care FSA, you will automatically receive a HealthEquity Healthcare Card (Card), generally within 2 weeks of your effective date of coverage. Your Card can only be used at:
  - Medical, dental, and vision health care providers
  - General merchandise stores that have an inventory system that meets IRS requirements
  - Select pharmacies

Note: If you are enrolled in the Copay Plan with HRA, see the "Using the Card for FSA and Copay Plan with HRA Expenses" section on page 5-14 for information about how the FSA and the HRA are coordinated to pay for eligible expenses.

- The CARES Act extended the list of FSA qualified expenses to include menstrual care products and eliminated the requirement for prescriptions for eligible over-the-counter (OTC) drugs. Please refer to the"Eligible (or qualified) expenses" section on page 5-15.

Limited Dental/Vision FSA rules

In addition to the information noted below, refer to the "Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA" section starting on this page, the "Using the Card with the Limited Dental/Vision FSA" section starting on page 5-13, and "The Limited Dental/Vision FSA" section on page 5-4 for other applicable rules.

- When you enroll in a Limited Dental/Vision FSA, you will automatically receive a HealthEquity Healthcare Card (Card) generally within 2 weeks of your effective date of coverage. Your Card can only be used at:
  - Dental providers
  - Vision providers
- Medical expenses and prescription drug expenses are not eligible for reimbursement under the Limited Dental/Vision FSA.

Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA

- You must use the money for eligible expenses that are incurred: (1) in the same year you contribute it or during the grace period described below and (2) while you are a participant. You cannot be reimbursed for expenses incurred before your participation begins or after your participation ends.
- If, as the result of a Qualified Event or termination of employment, you terminate your participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, expenses incurred after you are no longer a participant are not eligible for reimbursement, unless you are eligible and enroll for COBRA continuation coverage to extend your participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA.
- If you are enrolled in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA on December 31 of a plan year and have not exhausted your balance, you qualify for a grace period — January 1 through March 15 at 11:59 PM Central Time of the year following the plan year. This grace period extends the time period during which you can incur eligible expenses. Eligible expenses incurred during the grace period that are eligible for reimbursement will be reimbursed from the prior plan year's balance until that balance is exhausted. If you are also participating in the same FSA option during the plan year in which the expenses are incurred, then any eligible expenses that are not paid from the prior plan year's balance may be eligible to be paid from the current plan year's balance. **Please note:** Card use must occur prior to the March 15 at 11:59 PM Central Time grace period deadline in order to apply to the prior year. Any Card use after the March 15 at 11:59 PM Central Time grace period deadline will apply to the current year and cannot be used to pay for expenses incurred in the prior year.

  For example: You are a participant in the Full-Purpose Health Care FSA on December 31, 2021, you incur $100 worth of eligible expenses on January 15, 2022, and submit a request for reimbursement on January 30, 2022. At that time, you have a $50 balance still remaining in your 2021 Full-Purpose Health Care FSA. Accordingly, $50 of your $100 eligible expenses will be reimbursed to you from your 2021 account and the remaining $50 may be eligible to be reimbursed from your 2022 account if you have elected the Full-Purpose Health Care FSA for 2022.
- An eligible expense is incurred when the service is received, not when payment is made. For example, if you receive the service on May 10 but pay for services in June after receiving a billing statement, the expense is incurred on May 10. Similarly if you prepay for services, the expense is not incurred until the service is actually received.
- You must submit completed claims to HealthEquity and resolve all outstanding Card use verification requests by April 30 at 11:59 PM Central Time of the following plan year. The claim must include proper expense documentation for eligible expenses incurred during the plan year or during the applicable grace period. To ensure that your claims are complete by this date, submit your initial claims early in case you are asked for additional information or are missing any items. Claims, Card use verification requests, or expense documentation submitted after the April 30 at 11:59 PM Central Time deadline will not be reimbursed. A completed claim consists of a signed Pay Me Back claim form and required documentation, as determined by HealthEquity (for example, documentation from your provider that contains the provider's name, the patient's name, the date of service, description of product or service, and the amount to be reimbursed). An Explanation of Benefits from your health carrier generally is an acceptable form of documentation.
- With either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, Card transactions may be automatically verified. If your Card transaction is automatically verified, you will generally not have to submit a receipt to HealthEquity after the transaction. You are, however, required to keep each itemized receipt for tax purposes in the event it is needed for verification. See the "Using your HealthEquity Healthcare Card" section starting on page 5-10 for more information.
- If the April 30 at 11:59 PM Central Time claims submission deadline has passed and you have a remaining balance from the previous plan year, the previous plan year's balance is forfeited and you no longer have the opportunity to request additional reimbursements from that previous year's balance. You cannot receive a refund for the unused balance.

- After you enroll in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, you may not increase or decrease your elected contributions unless you have a Full-Purpose Health Care FSA- or Limited Dental/Vision FSA-related Qualified Event. For more information, refer to the "Qualified Events" table in "Chapter 1: Eligibility, Enrollment, and More."
- If your pay is not sufficient to cover your per pay period contributions or your contributions are otherwise missed and you owe any back contributions, you will experience double deductions until all missed contributions have been taken, or the last paycheck of the year, whichever comes first. For more information on arrears, see the "Paying for coverage" section on page 1-11.
- If you experience a Qualified Event and you increase your elected contributions, claims against the increased elected contribution amount must be incurred on, or after, the effective date of the newly elected annual contribution amount. Your new per-pay-period contribution amount will be calculated by subtracting your year-to-date contributions from your newly elected annual contribution amount and dividing the difference by the number of pay periods remaining for the plan year.

  For example:

  – Your original annual contribution for the Full-Purpose Health Care FSA option is $1,000 elected during Annual Benefits Enrollment.

  – Assuming 26 pay periods per plan year results in a $38.46 contribution per pay period.

  – A Qualified Event occurs on September 4.

  – You make a permitted election change, increasing your annual contribution to $2,750 for the plan year.

  – The effective date for the increased election is October 1. Assuming there have already been 20 pay periods under your prior election, your per-pay-period contributions will be increased from $38.46 to $330.13 for the remainder of the plan year ($2,750 minus $769.20 collected in the prior 20 pay periods leaves $1,980.80 to be divided between the remaining six pay periods).

  – You may only be reimbursed up to $1,000 for expenses incurred before October 1. However, if you have not incurred $1,000 worth of expenses by October 1, you can continue to incur eligible expenses during the remainder of the plan year and the applicable grace period. Eligible expenses incurred from October 1 through the end of the plan year (and during the applicable grace period) cannot exceed the difference between your increased election of $2,750 less the amount of any reimbursements for eligible expenses incurred prior to October 1.
- If you experience a Qualified Event and you elect to decrease your annual contributions but want to continue your participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, you may not elect to decrease your annual contribution below the amount you have already contributed up to the date the election change is effective. Your reduced annual contribution is also subject to the minimum per-pay-period contribution of $5.00 to continue your participation. Continuing your participation allows you to continue to file claims for eligible expenses incurred after the effective date of the change. If you experience a Qualified Event and you elect to decrease your annual contribution for expenses incurred after your election change is effective, your annual claims reimbursement is limited to the new reduced amount minus any prior reimbursements. Your new per-pay-period contributions will be calculated by subtracting your year-to-date contributions from your new annual contribution amount and dividing the difference by the number of pay periods remaining for the plan year.

  For example:

  – Your original annual elected contribution for the Full-Purpose Health Care FSA is $2,000 elected during Annual Benefits Enrollment.

  – Assuming 26 pay periods per plan year results in a $76.92 contribution per pay period.

  – A Qualified Event occurs on September 4.

  – You make a permitted election change, decreasing your annual contribution to $1,850 for the plan year.

  – The effective date for the decreased annual contribution election is October 1. Assuming there have already been 20 pay periods under your prior election, your per-pay-period contributions will be decreased from $76.92 to $51.92 for the remainder of the plan year ($1,850 minus $1,538.46 collected in the prior 20 pay periods leaves $311.54 to be divided between the remaining six pay periods). For expenses incurred after October 1, you may only be reimbursed up to $1,850 minus any prior reimbursements.
- Midyear election changes from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa are not allowed, even if you experience an applicable special enrollment right or Qualified Event that allows you to elect a different medical benefit option during the year. Refer to the "Qualified Events" table in "Chapter 1: Eligibility, Enrollment, and More."

For example:

– During Annual Benefits Enrollment, you enroll in the Copay Plan with HRA (including Out of Area) and elect to contribute to the Full-Purpose Health Care FSA.

– You get married midyear, and due to the special enrollment right, you add your new spouse to your medical coverage and you change your medical benefit plan from the Copay Plan with HRA (including Out of Area) to one of the high-deductible health plans.

– You cannot change from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA due to this midyear special enrollment right.

- You can either elect to increase or maintain your current election in the Full-Purpose Health Care FSA. In this example, you are unable to elect to decrease or drop your current election in the Full-Purpose Health Care FSA.
- You can continue to use your Full-Purpose Health Care FSA while your participation continues.
- Neither you nor Wells Fargo can make contributions toward your health savings account (including earned health and wellness dollars) while you are a participant in the Full-Purpose Health Care FSA. This means that if you have a midyear change to enroll in one of the high-deductible health plans but you continue to be enrolled in the Full-Purpose Health Care FSA, neither you nor Wells Fargo can contribute to an HSA.

- If you have a midyear special enrollment right or Qualified Event allowing you to enroll in one of the high-deductible health plans, in order to be able to make contributions to a health savings account, you must make a corresponding election to drop your Full-Purpose Health Care FSA if allowed per the "Qualified Events" table in "Chapter 1: Eligibility, Enrollment, and More." If you do not, or if you are not permitted to drop your Full-Purpose Health Care FSA in connection with the Qualified Event or special enrollment right, contributions cannot be made to your health savings account. Not all Qualified Events permit you to drop your Full-Purpose Health Care FSA. See the example in the previous bullet.
- If you are rehired or return to a regular or fixed term position within the same year, and you elect to participate in either the Full-Purpose Health Care FSA or Limited Dental/Vision FSA both prior to termination or loss of benefits eligibility and after your rehire or return to benefits eligibility, each period is separate and distinct. In addition, unused funds from your prior period cannot be used for expenses incurred after your rehire or return to benefits eligibility. You cannot contribute more than $2,750 for the entire plan year between the combined two periods of employment. If you also elected COBRA continuation coverage for your FSA during your interim employment periods, these contributions will also be included in the combined total, which cannot exceed $2,750 for the entire plan year.

  For example:

  - Your original annual elected contribution for the Full-Purpose Health Care FSA is $1,500 elected during Annual Benefits Enrollment with a January 1 effective date (assuming there are 26 pay periods in the year, $1,500 divided by 26 = $57.69 per-pay-period contributions).
  - Employment with Wells Fargo is terminated on March 15.
  - You can request reimbursement for eligible expenses up to the full $1,500 elected amount, as long as those expenses are incurred prior to March 31.
  - You are rehired on August 15 with coverage effective October 1 (the first of the month after one full calendar month of service). Assuming there have already been six pay periods under your prior election, you are eligible to elect $2,403.85 ($2,750 annual limit minus $346.15 taken in prior payroll deductions). However, you elected a $1,000 Full-Purpose Health Care FSA annual contribution amount upon your rehire (assuming six pay periods remain in the plan year, $1,000 divided by six remaining pay periods = $166.67 per-pay-period contributions).
  - You may only be reimbursed up to $1,000 for expenses incurred between October 1 and the end of the plan year, including the grace period. Any unused funds from your prior enrollment cannot be used for expenses incurred after your rehire.
- When you file your tax returns, you cannot deduct or claim a tax credit for expenses paid by either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA.

Your contributions

If you enroll in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, your before-tax pay will be reduced each pay period by the per-pay-period contribution amount. Your elected annual contribution will be divided by the number of eligible pay periods in the calendar year. If you enroll midyear because you are newly hired or newly eligible, or experience a Qualified Event, your elected annual contribution will be divided by the number of eligible pay periods remaining in the plan year. See the "Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA" section starting on page 5-5 if you experience a midyear Qualified Event that affects your annual contribution.

You can authorize contributions in any amount with a:

- Minimum of $130 per plan year or $5.00 per pay period
- Maximum of $2,750 per plan year

  Note: Maximum is per person, per employer and there is no household limit. If both spouses work at Wells Fargo, both can elect the maximum amount.

The Full-Purpose Health Care FSA and the Limited Dental/Vision FSA are bookkeeping accounts established to keep track of your contributions and reimbursements. When you enroll in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA option during the Annual Benefits Enrollment period, Wells Fargo credits your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA with your full annual elected contribution amount on January 1.

For example: If you elect to contribute $1,000 for the year, $1,000 will be available for reimbursement on the first day of January following the Annual Benefits Enrollment period during which the election was made. You can use the full $1,000 for eligible expenses incurred on January 1, the first day of the new plan year. If you are newly hired and enroll in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, Wells Fargo credits your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA with your full annual elected contribution amount on your first day of coverage.

How to enroll

New hire and employment classification change enrollment

If you are a regular or fixed term employee, you may enroll in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA. For more information, see the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" and the "Health Care FSA Plan options" section on page 5-3.

If you enroll during your designated enrollment period, your participation generally begins on the first of the month following one full calendar month of service in a regular or fixed term position. For more information, see the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More." If you enroll, you must participate for the remainder of the plan year (calendar year) unless you have a Qualified Event that permits dropping coverage. For more information, see the "Changing coverage" section in "Chapter 1: Eligibility, Enrollment, and More."

If you do not enroll during your initial designated enrollment period, you cannot elect to participate in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA until the first day of the plan year following the next Annual Benefits Enrollment period, unless you experience an eligible Qualified Event that permits you to make a midyear election. For more information, see the "Changing coverage" and the "Qualified Events" sections in "Chapter 1: Eligibility, Enrollment, and More."

Annual Benefits Enrollment

Participation in either the Full-Purpose Health Care FSA or Limited Dental/Vision FSA option does not continue automatically from year to year. You must make an affirmative annual contribution election during each Annual Benefits Enrollment period to participate the following plan year. During the Annual Benefits Enrollment period, you may make a new annual contribution election for the next plan year or choose not to enroll.

Rehire or return to a regular or fixed term position

If you are a rehired regular or fixed term employee, or you return to a regular or fixed term position in the same plan year in which you were previously enrolled, and you want to participate in either the Full-Purpose Health Care FSA or Limited Dental/Vision FSA option, you must reenroll during your designated enrollment period. In addition, your election amount after your rehire or return to a regular or fixed term position will be limited to the annual contribution limit minus any Full-Purpose Health Care FSA or Limited Dental/Vision FSA payroll contributions taken prior to your previous same plan year termination or move to a regular or fixed term position so that you do not exceed the applicable contribution limit for the plan year.

For more information about the Full-Purpose Health Care FSA or Limited Dental/Vision FSA after a rehire or return to a regular or fixed term position, see the "Health Care FSA Plan options" section on page 5-3 and the "Some rules to know" section starting on page 5-4.

Changing participation

Changes are restricted

IRS regulations restrict your ability to change your contributions to the Full-Purpose Health Care FSA or Limited Dental/Vision FSA during the plan year. You cannot change your contribution amount to your Full-Purpose Health Care FSA or Limited Dental/Vision FSA unless you have experienced an applicable Qualified Event.

For more information about Qualified Events, see the "Changing coverage" and "Qualified Events" sections in "Chapter 1: Eligibility, Enrollment, and More."

For more information on how a change in contributions, as a result of a Qualified Event, may impact the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, see the "Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA" section starting on page 5-5.

Employment classification change

If you begin participating in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA and then change your employment classification from a regular or fixed term position to an intern or flexible position, your contributions stop at the end of the month after the change in employment status. You may, however, still submit claims until April 30 of the following year for eligible expenses incurred up to the end of the month of your employment classification change. You may be eligible to continue participation in the applicable Full-Purpose Health Care FSA or the Limited Dental/Vision FSA under COBRA. For more information, see the "COBRA coverage" section starting on page 5-9.

Leave of absence

For information on contributions during a leave of absence, see "Appendix D: Leaves of Absence and Your Benefits."

Claims

If you participate in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, you can claim eligible expenses incurred during your approved leave of absence.

Annual Benefits Enrollment while on leave

If you have elected participation in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA and you are on a leave of absence on January 1 without recognized sources of income replacement, contributions, including any applicable missed contributions for the current plan year, will begin when you return to work in a regular or fixed term position. Your missed payroll deductions will be in arrears and will be taken

from future paychecks (double deductions will be taken until all missed contributions have been taken, or the last paycheck of the year, whichever comes first). For more information, see the ""Paying for coverage – regular and fixed term employees."" section on page 1-11. However, Wells Fargo credits your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA with your full annual elected contribution amount on January 1.

When participation ends

Participation in the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA ends on the last day of the month in which one of the following events occurs (or was processed, whichever is later):

- Your last day of employment or the last day of your severance eligibility period under the Wells Fargo & Company Severance Plan, whichever occurs later.[1]
- You no longer meet the eligibility requirements.
- You cancel participation, as permitted by Health Care FSA Plan provisions.
- You die.

Coverage will also end if the Health Care FSA Plan (or applicable option) is discontinued or terminated regardless of any of the events noted above[2].

1. If you are rehired by Wells Fargo as a regular or fixed term employee and your first day of reemployment occurs during your severance eligibility period, any benefits that are in effect on the day before your rehire will continue as a rehired employee. For more information see the "Rehired employees" section in "Chapter 1: Enrollment, Eligibility and More".
2. For more information on the Health Care FSA Plan's amendment and termination procedures, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

Your Card is deactivated when your participation ends. You may continue to file claims for eligible expenses incurred before the date your participation ends up until your available account balance is zero or until April 30 of the next calendar year, whichever occurs first. As noted above, eligible expenses are incurred when the service is received and not when you pay the provider.

For example: If you start participating in the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA at the beginning of the plan year and then terminate employment on May 15, your participation will end on May 31 and you may file claims for eligible expenses incurred between January 1 and May 31. You have until April 30 at 11:59 PM Central Time of the next calendar year to submit these claims.

If you have provided fraudulent information regarding the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA option (or otherwise committed fraud with respect to the Full-Purpose Health Care FSA or Limited Dental/Vision FSA), your participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA may be terminated (or you may not be permitted to participate in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA).

COBRA coverage

Employees who are no longer eligible to be enrolled in the Health Care FSA Plan due to termination of employment, the end of the severance eligibility period, or a reduction of hours of employment that results in loss of eligibility, may be offered the opportunity to continue participating in the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA option by electing COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) continuation coverage and making after-tax contributions if certain conditions are met.

In order to be able to elect COBRA continuation coverage, the amount remaining in your FSA as of the date of the COBRA qualifying event must be larger than the maximum amount that you can be required to pay for COBRA coverage for the remainder of the plan year. This would generally be the case where your total year-to-date FSA contributions are greater than the amount of your eligible expenses submitted for reimbursement as of the date of the qualified event. Electing COBRA continuation coverage and making after-tax contributions allows you additional time to incur expenses as only expenses incurred while you participate are eligible for reimbursement. If your total year-to-date FSA contributions are less than the amount of your eligible expenses submitted for reimbursement as of the date of the qualified event, you are not eligible to elect COBRA continuation.

Participation can continue only until the end of the current plan year. Participation will cease if you stop making COBRA payments. If you do stop making COBRA payments, your participation will end before your COBRA eligibility and before the end of the plan year. For more information, see "Appendix E: Continuing Coverage Under COBRA."

If you die

If you die, your eligible dependents (as defined in the "Eligible dependents" section on page 5-10) or the executor of your estate may continue to file claims for eligible expenses incurred while you were a participant in the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA until your applicable account balance is used up or the final claim deadline, whichever occurs first. Additional documentation may be required by HealthEquity, such as a death certificate, when claims are filed after the participant's death. Your eligible dependents may be eligible to continue coverage under the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA option by enrolling through COBRA and making after-tax contributions. (Refer to the "COBRA coverage" section above.)

Using the Full-Purpose Health Care FSA and Limited Dental/Vision FSA

General information

The Full-Purpose Health Care FSA allows you to be reimbursed for eligible medical, dental, and vision expenses (for example, copayments, orthodontia, eyeglasses, and prescribed and eligible over-the-counter medications for you or your eligible dependents) that are not reimbursed by another source.

The Limited Dental/Vision FSA allows you to be reimbursed only for eligible dental or vision expenses that are not reimbursed by another source. Eye drops and treatments; over-the-counter products for dental, oral and teething pain; and toothache and teething pain reliever are eligible under the Limited Dental/Vision FSA. Medical and prescription drug expenses are not eligible for reimbursement under the Limited Dental/Vision FSA.

Using your Full-Purpose Health Care FSA and Limited Dental/Vision FSA dollars

Options:	Best used when:	Additional details can be found:
HealthEquity Healthcare Card	You want to pay for an eligible expense from available FSA funds on the date the eligible expense is incurred or after receiving a balance due bill for eligible expenses.	"Using your HealthEquity Healthcare Card" section on page 5-10
Pay My Provider	You want to request that the outstanding balance of a bill for an eligible expense be paid directly to a provider from available FSA funds.	"Pay My Provider (PMP) payment option" section on page 5-17
Pay Me Back	You paid the provider with your personal funds and want to be reimbursed for the eligible expense from available FSA funds.	"Filing a claim" section on page 5-16

Eligible dependents

You can use either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA to be reimbursed for eligible expenses for any of the following people:

- Yourself
- Your spouse
- Your domestic partner, **only** if he or she qualifies as your tax dependent under the Internal Revenue Code
- Your qualifying child, including adult children up to age 26*
- Your qualifying relative*

* Special rules may allow a dependent's expense to be eligible for reimbursement under the FSA even when that dependent does not qualify to be claimed as your tax dependent on your tax return form. You should consult with a tax advisor regarding any tax implications.

Using your HealthEquity Healthcare Card

When you enroll in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA option, you will automatically receive a HealthEquity Healthcare Card (Card) generally within 2 weeks of your effective date of coverage (if you do not receive your card, contact HealthEquity). You may receive additional Cards for a spouse or adult-aged (18 or older) eligible dependents by visiting https://participant.wageworks.com, or by contacting HealthEquity Member Services, and you must cancel dependent Cards by calling HealthEquity Member Services when the dependent is no longer eligible. The Card makes it easier to use the amount you've contributed to your Full-Purpose Health Care FSA or Limited Dental/Vision FSA by giving you a convenient way to pay for qualified expenses directly from your FSA.

Cardholders have a Personal Identification Number (PIN), which gives you the option to select "debit" and enter the PIN at the point of sale. You cannot use the PIN for cash access at ATMs or merchants. You are not required to use the PIN and all merchants may not be able to accept PIN transactions. You may continue to select the "credit" option and sign the receipt. Please call HealthEquity at 1-877-924-3967 if you forget your PIN or have additional questions about your PIN.

The dollar limit on your Card will be the amount you elected to contribute to your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA during the Annual Benefits Enrollment period or your initial enrollment period (minus any amounts already reimbursed to you or paid by the Card).

The dollar limit on your Card will also be adjusted to reflect allowed midyear changes to your annual contribution (minus any amounts already reimbursed to you or paid by the Card).

Your Card must be activated before using it to pay for eligible expenses. By activating your Card, you agree to the terms and provisions outlined in the Terms and Conditions of Use included with your Card. Be sure to read the material carefully.

Replacement cards

Call HealthEquity at 1-877-924-3967 immediately if your Card is lost or stolen.

Unauthorized transactions

You cannot stop payment to merchants for transactions made through the use of the Card. However, if you see any unauthorized transactions, you can contact HealthEquity within 60 days of the transaction date. Call HealthEquity at 1-877-924-3967 to request the form or send your completed form, via mail or fax (do not upload your request to the HealthEquity site), to the address below.

HealthEquity
Attn: Card Operations – Dispute
PO Box 60068
Phoenix, AZ 85082-0068
Fax: 1-866-672-0899

HealthEquity will research your disputed transaction once they receive the completed form. If HealthEquity determines that an error occurred, HealthEquity will credit your FSA accordingly. If HealthEquity determines no error has occurred, you will receive a written explanation from HealthEquity and you agree to settle all disputes about Card transactions with the merchant where the dispute arose.

Card suspensions

If HealthEquity is unable to determine that a Card transaction was used for eligible expenses according to IRS regulations, HealthEquity will ask you to submit a Card Use Verification Form. If HealthEquity does not receive the form with all required documentation within 90 days of the transaction, your Card will be suspended and the amount will be deducted from your next requested Pay Me Back reimbursement check.

Card suspensions can be resolved by one of the following methods:

1. Providing verification of the original expense by downloading the EZ Receipts mobile app or logging into your account at https://participant.wageworks.com.
2. Providing verification for a substitute expense that occurred in the same year and has not already been reimbursed.
3. Reimbursing the amount of the original expense. Reimbursements can be made by repaying your account on the HealthEquity Participant Site, personal check, money order, or your personal bank's online bill pay system. In order to make sure that your repayment gets posted to the correct account, make sure that account documentation is included on your check, money order, or online bill pay.

Card suspensions carry over from year to year. If your Card is suspended due to a prior year's expense, your current year's expenses cannot be used to offset the prior year's expense. In addition, while your Card is suspended, Pay Me Back and Pay My Provider are your only options for using your account.

Using the Card with the Full-Purpose Health Care FSA

If you are enrolled in the Full-Purpose Health Care FSA, your Card can be used to pay for qualified out-of-pocket health care expenses at merchants that accept Visa® Cards for out-of-pocket costs, such as:

- Copayments, coinsurance, and deductibles for eligible medical, dental, and vision expenses
- Dental and orthodontic expenses
- Vision expenses and LASIK surgery
- Hospital charges
- Prescription drugs (at time of purchase only)
- Eligible over-the-counter drugs and menstrual care products

All stores and most pharmacies selling FSA-eligible items will have to have an inventory system that meets IRS requirements in place for the store to accept the Card. Such systems ensure that you can only use your Card for eligible items. As a result, when you use your Card at a store with such a system, you may not need to submit receipts to HealthEquity for verification after the purchase if you are enrolled in the Full-Purpose Health Care FSA. The most current list of stores with inventory systems that meet IRS requirements can be found at sigis.com.

The CARES Act extended the list of FSA qualified expenses to include menstrual care products and eliminated the requirement for prescriptions for eligible over-the-counter (OTC) drugs.

If you are enrolled in the Full-Purpose Health Care FSA and you use the Card at a health care provider, and HealthEquity is unable to verify your patient out-of-pocket responsibility, HealthEquity will require that you submit an itemized receipt or an Explanation of Benefits from your medical, dental, or vision plan to verify your patient out-of-pocket responsibility.

If you are enrolled in the Full-Purpose Health Care FSA and you use the Card at a pharmacy that does not have an inventory system that meets IRS requirements, HealthEquity will require that you submit an itemized receipt or the Explanation of Benefits from your medical plan to verify that the transaction was for an eligible health care product or service. If your Card is used and accepted for the purchase of over-the-counter drugs indicated on the eligible expense list at https://participant.wageworks.com, you may be required to submit an itemized receipt.

If HealthEquity is unable to determine that a Card transaction was used for eligible health care expenses according to IRS regulations, HealthEquity will ask you to submit a Card Use Verification Form. If HealthEquity does not receive the form with all required documentation within 90 days of the transaction, your Card will be suspended and the amount will be deducted from your next requested Pay Me Back reimbursement check.

For more information on resolving Card suspensions, see the "Card suspensions" section on page 5-11.

It is your responsibility to manage your balance and allow ample time for all transactions (including Card transactions, Card Use Verification Forms, and claims and expense documentation) to clear. Also keep in mind that reimbursement requests can be used to offset outstanding Card use verifications, so make sure all Card Use Verification Forms are submitted in a timely manner. Please see the "Required expense documentation" section on page 5-16 for more information.

Access your account at https://participant.wageworks.com regularly to see if you have any Card transactions that need verification. Make sure you page through all Alerts & Messages that pop up when you first access the HealthEquity website as they are designed to notify you of Card transactions that require verification. Simply follow the prompts online to respond to the Card use verification request to restore your account to its good standing.

Go to HealthEquity Support Center at https://participant.wageworks.com to view the web tutorial to learn more about the Card Use Verification Form and process.

Unverified Card transactions can be resolved as follows:

1. Go to https://participant.wageworks.com and download your latest Card Use Verification Form.
2. Print out the prefilled Card Use Verification Form.
3. Review the form for information about how and where to submit your receipts, payments, or both.
4. Complete and sign the form.
5. Submit the form along with a detailed receipt as indicated on the form. For more information, see the "Required expense documentation" section on page 5-16.

For your receipt (or any documentation) to be valid, it must include the following five specific pieces of information required by the IRS:

- Patient name
- Provider name
- Date of service
- Type of service
- Your cost (your copayment, coinsurance, or deductible amount, or the portion not covered by your insurance)

After HealthEquity receives your Card Use Verification Form and required documentation, if you have a valid email address on file you will receive an automatic email notification when your form has been processed, and if you do not have a valid email on file you will receive notification by mail when your form has been processed. If denied, you will be advised of the denial reason, such as ineligible expense.

When using your Card during the grace period (January 1 to March 15 at 11:59 PM Central Time), the Card will automatically use your previous year's funds first if any funds remain.

In addition, Card use must occur prior to the March 15 at 11:59 PM Central Time grace period deadline in order to apply to the prior year. Any Card use after the March 15 at 11:59 PM Central Time grace period deadline will apply to the current year and cannot be used to pay for expenses incurred in the prior year. **Please keep in mind that if you have any unreimbursed claims to submit for the previous year, you must submit these claims before using your Card during the grace period.** Otherwise, if you use your Card for claims incurred during the grace period, you may not have sufficient funds left in your previous year's account to be reimbursed for claims incurred in the previous year. If you do not have any funds remaining from the previous year or were not enrolled in the previous year, the Card will automatically deduct funds from the available balance of your current year's Full-Purpose Health Care FSA. Please refer to the "Important note:" on page 5-14 in the "Using the Card with the Limited Dental/Vision FSA" section starting on page 5-13 regarding grace period funds if you are enrolled in the Full-Purpose Health Care FSA during the current year and elect the Limited Dental/Vision FSA in the subsequent year.

When using your Card, note the following:

- Your Card can only be used to pay exact amounts you owe for qualified Full-Purpose Health Care FSA expenses. If your purchase includes nonqualified expenses, you must pay for those items separately with another form of payment and you will not be able to manually claim these expenses later.
- If your qualified Full-Purpose Health Care FSA items are not purchased with your Card, you must submit a claim with a copy of your valid receipt (or other valid documentation such as an Explanation of Benefits) to be reimbursed. For more information, see the "Using the Full-Purpose Health Care FSA and Limited Dental/Vision FSA" section on page 5-10.
- For mail-order prescriptions under the Full-Purpose Health Care FSA, you may enter the Card number on the prescription mail-order form and submit it to the mail-order company, similar to any other Visa transaction. Payment will be taken directly from available funds in your Full-Purpose Health Care FSA and paid to the mail-order company for eligible expenses.
- You can use the Card to pay a bill for qualified Full-Purpose Health Care FSA expenses. Write the Card number on your statement and send it back to the health care provider. Payment will be taken directly from available funds in your Full-Purpose Health Care FSA and paid to the health care provider for eligible expenses.
- You will always be required to submit verification of expenses when using your Card to pay a bill. You may want to consider the Pay My Provider option instead. See the "Pay My Provider (PMP) payment option" section on page 5-17 for more information.

- If your health care provider does not accept Visa Cards as a form of payment, you can set up a Pay My Provider payment through your Full-Purpose Health Care FSA to have HealthEquity issue the payment on your behalf. This method is similar to a bill payment feature you might use with your personal checking account. See the "Pay My Provider (PMP) payment option" section on page 5-17 for more information.
- If you use your Card to pay for ineligible expenses or expenses for which you do not have the required documentation, you will be required to pay back the improper payment amounts to HealthEquity for credit to the Full-Purpose Health Care FSA. See the "Ineligible payments or reimbursements" section on page 5-17 for more information.

Using the Card with the Limited Dental/Vision FSA

If you are enrolled in the Limited Dental/Vision FSA, your Card can only be used to pay for qualified out-of-pocket dental and vision provider expenses. For all other dental and vision expenses (for example, reading glasses purchased from a general merchandise store), you will need to pay out of pocket and submit a claim, with required documentation, for reimbursement. You may use your Card at a dental or vision provider that accepts Visa Cards for out-of-pocket dental and vision costs, such as:

- Copayments, coinsurance, and deductibles for eligible dental and vision expenses
- Dental and orthodontic expenses
- Vision expenses and LASIK surgery

Note: You may not use your Card to pay for any medical, prescription drug, or other health care expenses. While over-the-counter drugs are generally not available for reimbursement under the Limited Dental/Vision FSA, three categories of over-the-counter expenses that are eligible without a prescription: (1) eye drops and treatments, (2) over-the-counter products for dental, oral and teething pain, and (3) toothache and teething pain reliever.

If you are enrolled in the Limited Dental/Vision FSA and you use the Card at a dental or vision provider, and HealthEquity is unable to verify your patient out-of-pocket responsibility, HealthEquity will require that you submit an itemized receipt or an Explanation of Benefits from your dental or vision plan to verify your patient out-of-pocket responsibility.

If HealthEquity is unable to determine that a Card transaction was used for eligible dental or vision expenses according to IRS regulations, HealthEquity will ask you to submit a Card Use Verification Form. If HealthEquity does not receive the form with all required documentation within 90 days of the transaction, your Card will be suspended and the amount will be deducted from your next requested Pay Me Back reimbursement check. For more information on resolving Card suspensions, see the "Card suspensions" section on page 5-11.

It is your responsibility to manage your balance and allow ample time for all transactions (including Card transactions, Card Use Verification Forms, and claims and expense documentation) to clear. Also keep in mind that reimbursement requests can be used to offset outstanding Card use verifications, so make sure all Card Use Verification Forms are submitted in a timely manner. Please see the "Required expense documentation" section on page 5-16 for more information.

Access your account at https://participant.wageworks.com regularly to see if you have any Card transactions that need verification. Make sure you page through all Alerts & Messages that pop up when you first access the HealthEquity website as they are designed to notify you of Card transactions that require verification. Simply follow the prompts online to respond to the Card use verification request to restore your account to its good standing.

Access HealthEquity Support Center at https://participant.wageworks.com to view the web tutorial to learn more about the Card Use Verification Form and process.

Unverified Card transactions can be resolved as follows:

1. Go to https://participant.wageworks.com and download your latest Card Use Verification Form.
2. Print out the prefilled Card Use Verification Form.
3. Review the form for information about how and where to submit your receipts, payments, or both.
4. Complete and sign the form.
5. Submit the form along with a detailed receipt as indicated on the form. For more information, see the "Required expense documentation" section on page 5-16.

For your receipt (or any documentation) to be valid, it must include the following five specific pieces of information required by the IRS:

- Patient name
- Provider name
- Date of service
- Type of service
- Your cost (your copayment, coinsurance, or deductible amount, or the portion not covered by your insurance)

After HealthEquity receives your Card Use Verification Form and required documentation, if you have a valid email address on file you will receive an automatic email notification when your form has been processed, and if you do not have a valid email on file you will receive notification by mail when your form has been processed. If denied, you will be advised of the denial reason, such as ineligible expense.

When using your Card during the grace period (January 1 to March 15 at 11:59 PM Central Time), the Card will automatically use your previous year's funds first if any funds remain. In addition, Card use must occur prior to the March 15 at 11:59 PM Central Time grace period deadline in order to apply to the prior year.

Any Card use after the March 15 at 11:59 PM Central Time grace period deadline will apply to the current year and cannot be used to pay for expenses incurred in the prior year. **Please keep in mind that if you have any unreimbursed claims to submit for the previous year, you must submit these claims before using your Card during the grace period.** Otherwise, if you use your Card for claims incurred during the grace period, you may not have sufficient funds left in your previous year's account to be reimbursed for claims incurred in the previous year. If you do not have any funds remaining from the previous year or were not enrolled in the previous year, the Card will automatically deduct funds from the available balance of your current year's Limited Dental/Vision FSA.

Important note: If you are enrolled in a Limited Dental/Vision FSA, your Card is limited to dental and vision provider expenses. Therefore, any grace period medical expenses under a prior Full-Purpose Health Care FSA must be paid out of pocket and you'll need to submit a paper claim, with required documentation, for reimbursement.

When using your Card, note the following:

- Your Card can only be used to pay exact amounts you owe for qualified dental and vision expenses. If your purchase includes nonqualified expenses, you must pay for those items separately with another form of payment and you will not be able to manually claim these expenses later.
- If your qualified Limited Dental/Vision FSA items are not purchased with your Card, you must submit a claim with a copy of your valid receipt (or other valid documentation such as an Explanation of Benefits) to be reimbursed. For more information, see the "Claims and appeals" section starting on page 5-16.
- You can use the Card to pay a bill for qualified dental and vision services. Write the Card number on your statement and send it back to the dental or vision care provider. Payment will be taken directly from available funds in your Limited Dental/Vision FSA and paid to the dental or vision care provider for eligible expenses.
- You will always be required to submit verification of expenses when using your Card to pay a bill. You may want to consider the Pay My Provider option instead. See the "Pay My Provider (PMP) payment option" section on page 5-17 for more information.
- If your dental or vision provider does not accept Visa Cards as a form of payment, you can set up a Pay My Provider payment through your Limited Dental/Vision FSA to have HealthEquity issue the payment on your behalf. This method is similar to a bill payment feature you might use with your personal checking account. See the "Pay My Provider (PMP) payment option" section on page 5-17 for more information.
- If you use your Card to pay for ineligible expenses or expenses for which you do not have the required documentation, you will be required to pay back the improper payment amounts to HealthEquity for credit to the Limited Dental/Vision FSA. See the "Ineligible payments or reimbursements" section on page 5-17 for more information.

Using the Card for FSA and Copay Plan with HRA Expenses

If you are enrolled in the Full-Purpose Heath Care FSA and are also enrolled in the Copay Plan with HRA, available HRA funds will be applied first for all eligible medical and pharmacy expenses covered by the Copay Plan with HRA. When HRA funds are completely exhausted, any available FSA balance will then be applied to these expenses.

You will receive one HealthEquity Healthcare Card to access both the FSA or HRA balance, as applicable.

Your available FSA balance will be applied to eligible expenses not covered by the Copay Plan with HRA.

- Use your Card to pay for eligible medical and prescription drug expenses for anyone enrolled in the Copay Plan with HRA. FSA funds will not be used to reimburse these expenses until your available HRA funds are exhausted.
- Use a Pay Me Back or Pay My Provider claims submission to receive reimbursement from your FSA for any eligible expenses incurred by a dependent not enrolled in the Copay Plan with HRA.
- Use your Card to pay for eligible expenses for you or any of your eligible dependents from your FSA. You may also file a Pay Me Back or Pay My Provider claim if you don't use your Card.

The importance of keeping receipts

Because the Full-Purpose Health Care FSA and Limited Dental/Vision FSA are IRS-regulated benefits, you should save all of your related itemized receipts. HealthEquity may contact you to submit a receipt to verify an expense.

When asked to verify an expense, you will need to submit the original detailed receipt to show that you paid for eligible products or services or both. For more information, see the "Required expense documentation" section on page 5-16.

If you are not able to provide the required receipt documentation for your original expense, you may substitute another expense and the related receipt for any eligible products or services that you have not previously claimed through your Full-Purpose Health Care FSA or Limited Dental/Vision FSA.

Misplaced receipts

If you can't produce a receipt for an expense, your options may range from submitting a substitute receipt to paying back the FSA for the amount of the transaction. Access your HealthEquity account to review your options.

If there are Card transactions that require your attention, you will be notified when you access your account online. Simply follow the prompts to submit your Card receipt. Your prompt attention is required to resolve any amount that requires substantiation. The claims administrator, HealthEquity, is required to ensure that 100% of FSA funds are used only for eligible products and services and that any ineligible payments are not reimbursed.

If such receipts aren't sent in the time frame indicated in the correspondence, your Card may be suspended until the issue is resolved. For information on resolving Card suspensions, see the "Card suspensions" section on page 5-11.

Eligible (or qualified) expenses

To be eligible for reimbursement from your FSA, the expense must be as follows:

- **For the Full-Purpose Health Care FSA**, the expense must be for medical, dental, or vision care as defined in Internal Revenue Code Section 213(d) (except for insurance premiums and qualified long-term care services). The CARES Act extended the list of FSA qualified expenses to include menstrual care products and eliminated the requirement for prescriptions for eligible over-the-counter (OTC) drugs. For more information, see the eligible expense list at https://participant.wageworks.com.
- **For the Limited Dental/Vision FSA**, the expense must be for dental or vision as defined in Internal Revenue Code Section 213. While over-the-counter drugs are generally not available for reimbursement under the Limited Dental/Vision FSA, three categories of over-the-counter expenses that are eligible without a prescription: (1) eye drops and treatments, (2) over-the-counter products for dental, oral and teething pain, and (3) toothache and teething pain reliever.
- Premiums or contributions for medical coverage are not eligible for reimbursement from either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA.
- The HealthEquity website at https://participant.wageworks.com provides a list of eligible expenses, including eligible over-the-counter items. The website also identifies those items that require a prescription or letter of medical necessity under the Full-Purpose Health Care FSA (see the "Letter of Medical Necessity" section on this page for more information).
- Incurred while you are participating in the FSA.
- For your or your eligible dependents' benefit.
- Incurred during the plan year or within the grace period of January 1 to March 15 at 11:59 PM Central Time of the following plan year. For more details about the grace period, see the "Some rules to know" section on page 5-4.
- Not reimbursed by another source.

Note: An expense is incurred when the service is received, not when payment is made. However, the IRS allows for advance payment for orthodontia expenses if it is required to receive the services.

Ineligible expenses

The FSAs do not allow reimbursements for certain specific expenses, including but not limited to the items listed below.

Note: The ineligible expenses listed below apply to either the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, as applicable. **Medical and prescription drug expenses are never allowed under the Limited Dental/Vision FSA.**

- Charges for the following are ineligible expenses, even if recommended by your doctor:
  - Charges for any illegal treatment
  - Cosmetic treatment or surgery, unless it improves a deformity due to a birth defect, disease, or trauma
  - Drugs or over-the-counter products that are considered cosmetic or used solely for cosmetic purposes (for example, over-the-counter products or prescriptions used to treat hair loss, thinning hair, unwanted hair growth, hair removal, or all of these factors, or for teeth whitening procedures, products, or both)
  - Exercise, athletic, or health club membership (except as noted under Eligible Expenses on https://participant.wageworks.com)
  - Household help
  - Massages
  - Nursing care for a healthy baby
  - Weight loss programs (except as specifically described under Eligible Expenses on https://participant.wageworks.com)
- Claims filed after the claims filing deadline.
- Concierge fees and expenses for health care services, unless itemization is provided for each date of service.
- Expenses incurred after the Health Care FSA Plan ends or your participation in the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA option ends.
- Expenses incurred before your effective date of participation in the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA.
- Expenses not allowed as a deduction or credit for federal income tax purposes.
- Expenses paid for with HRA or HSA dollars.
- Expenses you also claim as a deduction or credit for federal or state income tax purposes.
- Accident and health insurance premiums or expenses for qualified long-term care insurance services.
- In addition to all of the above ineligible expenses, the Limited Dental/Vision FSA does not allow reimbursement for medical and prescription drug expenses. Additionally, most over-the-counter drugs and supplies are not eligible under the limited Dental/Vision FSA. See the eligible expense list on HealthEquity's website at https://participant.wageworks.com.

Letter of Medical Necessity

Per IRC Sec 213(d)(1), if your provider believes the service or purchase is medically necessary for you or your eligible dependent(s), your medical care provider must complete a Letter of Medical Necessity for any service or product listed as "Yes (Letter)" under the Covered column on the eligibility list at https://participant.wageworks.com. You may also obtain a claim form at https://participant.wageworks.com.

In order for the expense referred to on the Letter of Medical Necessity to be reimbursed, you must attach the detailed receipt or Explanation of Benefits from your Medical Insurance Provider and complete a claim form (certain expenses may require additional documentation). Documentation must include the date of service, the services rendered or product purchased, and the person for whom the services were rendered and the amount charged. These documents are required with each claim filed.

Claims and appeals

HealthEquity is the claims administrator and processes requests for reimbursement from the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA. HealthEquity is the named fiduciary for claims and appeals under ERISA and has the sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the Health Care FSA Plan and respective options. Procedures for filing claims under the Full-Purpose Health Care FSA and Limited Dental/Vision FSA are set forth below.

Additional claims and appeals information for the Health Care FSA Plan is included in "Appendix A: Claims and Appeals."

Filing a claim

To be reimbursed for an eligible expense from the applicable Full-Purpose Health Care FSA and Limited Dental/Vision FSA, file a completed and signed Pay Me Back claim form with the claims administrator, HealthEquity. If you are using your Card to pay for eligible expenses under a Full-Purpose Health Care FSA or Limited Dental/Vision FSA, you do not need to file an additional claim form. You do need, however, to save your itemized receipts in case verification is required by HealthEquity.

The claim form is available to you online. You can access the HealthEquity website at https://participant.wageworks.com.

You may file your claim by one of the following methods:

- Using the website, you can complete an online claim form at https://participant.wageworks.com, and upload your scanned supporting expense documentation for your claim submission.
- You can use the HealthEquity mobile app. It's a quick and easy way to submit claims and receipts. This app should be used on personal devices only and should not be used on Wells Fargo owned devices.
- Fax the completed and signed claim form along with all required supporting expense documentation to HealthEquity at 1-877-353-9236 (keep a copy of the faxed documentation and the fax confirmation)
- Mail the completed and signed claim form, along with all required supporting expense documentation, to:

  HealthEquity Claims
  Appeal Board
  PO Box 34700
  Louisville, KY 40232

See the "Required expense documentation" section starting on this page for more information.

Claims filing time frame

Claims for expenses incurred during a plan year (or applicable grace period) must be postmarked, faxed, or electronically filed as noted above by April 30 at 11:59 PM Central Time of the following year. You can file a claim as soon as you have incurred an eligible expense or accumulate your expenses and file them together. You may submit claims under the applicable FSA only for expenses incurred while you were a Full-Purpose Health Care FSA or Limited Dental/Vision FSA participant.

If, following the April 30 at 11:59 PM Central Time deadline, you have a remaining balance in your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA after all eligible expenses for the prior plan year have been reimbursed, your remaining balance will be forfeited and you will lose the opportunity to request additional reimbursements from this balance. For example, if you have not filed for reimbursement of your eligible expenses for your 2021 Full-Purpose Health Care FSA or Limited Dental/Vision FSA option by April 30, 2022, at 11:59 PM Central Time, any remaining funds will be forfeited. Forfeited balances will remain the property of Wells Fargo & Company and may be used for any purpose permitted by applicable law, including paying for administrative expenses for the Health Care FSA and for the benefit of plan participants and their dependents. You cannot receive a refund for the unused balance.

Required expense documentation

Required documentation may include the following, as determined by HealthEquity:

- For medical, dental, or vision copayment or coinsurance expenses related to health care services, an Explanation of Benefits from your medical, dental, or vision plan after your claim has been processed, indicating the patient name, date of service, type of service, service provider, amount charged, amount paid by the applicable plan, and the amount you owe.
- For medical, dental, or vision expenses, a copayment receipt, indicating the patient name, date of service, provider, and copayment amount paid. The receipt must state that it is a copayment receipt.

- If you do not have medical, dental, or vision coverage under a health plan, you must provide evidence of your expense that includes an itemized billing statement from the provider indicating the patient name, date of service, type of service, service provider, and amount charged for the service. Balance due statements, general statements of account, credit card receipts, cash register receipts, or canceled checks are not acceptable forms of documentation.
- Over-the-counter drugs and medicines are eligible for reimbursement under the Full-Purpose Health Care FSA. Some require a letter of medical necessity (when noted as a requirement on the eligible expense list on HealthEquity's website at https://participant.wageworks.com — see the "Letter of Medical Necessity" section on page 5-15 for more information). In addition, you must submit a detailed cash register receipt that shows the description of the item (for example, allergy medicine), where the item was purchased, the charge for the item, and the date the item was purchased.

Keep copies of all documentation submitted. If you fax your documentation, keep a copy of the faxed documentation and the fax confirmation until you have confirmed that HealthEquity has processed your claim or verified any Card transactions and you have received your reimbursement.

Pay My Provider (PMP) payment option

Pay My Provider (PMP) gives you the ability to have HealthEquity make a payment directly from your account to your provider for eligible expenses for Full-Purpose Health Care FSA or Limited Dental/Vision FSA transactions. You can request a one-time or recurring payment.

You can set up a PMP payment (similar to online bill pay with your personal checking account) to come directly out of the current account balance in your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA. An itemized invoice or other appropriate proof of service is required before PMP payments can be issued. The invoice or other documentation must include the dates of service, type of service, service provider, patient's name, and cost of service. The payment request will remain in the system until the documentation is submitted, but recurring requests that continue through the subsequent plan year, under the same plan, will not have payments to providers issued until the new plan year begins on January 1. One-time requests will be processed and distributed just a few days after the submitted invoice or documentation has been approved (payment requests may not be entered before the service start date). Recurring payments will be mailed on the requested payment date. You are permitted to enter a requested payment date that is up to 10 calendar days before the due date shown on the contract, if required. A one-time payment cannot be canceled once it is submitted. A recurring payment, however, may be canceled up to 10 days before the requested payment date.

To request a PMP payment, sign on to https://participant.wageworks.com, and follow the necessary prompts to submit (mail, fax, or scan and upload) your itemized invoice or other appropriate documentation to complete your Pay My Provider request.

Claim payment

Your eligible claims will be paid up to your current account balance. For the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA option, the total annual contribution amount you elect for the plan year is available for you to use as of the first day of the plan year. As a result, your "current account balance" at any point during the plan year is that amount less any claims paid.

You will be reimbursed for claims the same way you receive your Wells Fargo pay. If you receive your pay by direct deposit, your reimbursement will be deposited to the same account (if you have more than one direct deposit account, your reimbursement will be deposited into the balance account). If you receive your pay by check, you'll receive your reimbursement by check. **Note:** If you are not enrolled in an FSA in the current year and are submitting claims incurred during the grace period for your prior year balance, you will be reimbursed by check.

After your claim for reimbursement has been processed, you will receive your reimbursement notification by email and if there is no email address for you on file with HealthEquity, you will receive a print version by mail. The minimum claim payment is $25. Claims will not be paid until they total at least $25 (except for the final claim payment for the plan year). This minimum reimbursement amount does not apply to Card transactions for eligible expenses.

Ineligible payments or reimbursements

If you use your Card to pay for ineligible expenses or if you receive reimbursements from the FSA that later are found to be ineligible or for which you do not have the required documentation, you will be required to pay back the improper payment amounts to HealthEquity for credit to the FSA. HealthEquity will notify you when this happens.

Your options for repayment are either:

- Log in to your account at https://participant.wageworks.com where an alert message will be viewable; click "GO TO NOW" to view a list of all transactions; then click "NEED CARD RECEIPT" to view a list of those transactions requiring a receipt and click a transaction; then click "SUBMIT REPAYMENT" and follow the prompts to enter your personal credit card or e-check information for the amount of repayment. You also have the option to send a check. This repayment will make the amount available for eligible products and services if the reimbursement is requested within the plan year and the appropriate deadlines are followed.

- Do nothing, and the amount under Receipt or Repayment Needed will be deducted from your next payment for claims. This is the automatic repayment option that is available if your balance will cover the amount. If not, you can repay as described above.

If you fail to make this repayment, Wells Fargo may withhold the amount of the improper payment from your wages or other compensation to the extent consistent with applicable law. Wells Fargo or HealthEquity may also withhold making reimbursement on future valid claims until the amount due to be repaid is recovered. Your Card will be suspended, you will not be able to use your Card until all repayments due are made, and you may be subject to corrective action, including termination of your employment. For information on resolving Card suspensions, see the "Card suspensions" section on page 5-11.

Account activity and status

Access your account online to review and print your real-time account information at any time of the day or month. Your account activity and status include information about:

- Your current and available funds
- Ineligible payments or your recent payments, claims, and reimbursements
- Special messages about your account

Make sure to review your account activity and status thoroughly.

HealthEquity will provide you with critical activity-based email alerts, such as the claims payment and Card use verification notices. You will be able to check your balance 24 hours a day, 7 days a week by accessing your account at https://participant.wageworks.com or by calling HealthEquity at 1-877-924-3967.

The different statuses for each of your Card transactions are:

- **Pending.** HealthEquity is in the process of collecting information about this Card transaction from various sources and possibly the merchant. If HealthEquity is able to obtain information to verify this Card transaction paid for eligible products and services, you will not be required to submit a receipt, other documentation, or a repayment. If not, you will be asked to do so in this section of next month's statement. In any case, be sure to save your receipts with your important tax documents for the year.
- **No (Further) Action Required.** HealthEquity was able to resolve this amount without further action required from you, based on information available to HealthEquity from a receipt, other documentation, or a repayment you submitted.
- **Receipt or Repayment Needed.** HealthEquity was not able to verify that this amount of the Card transaction was used to pay for eligible products and services. You are now required to submit a receipt or other documentation that describes exactly what you paid for or repay the FSA for the expense. Pay Me Back claims received before verification of a transaction will be applied to the outstanding amount and not reimbursed. Refer to the Card Use Verification Form for more information about your options to resolve this amount.
- **See Card Use Verification Form** (instructions). A Card Use Verification Form contains a list of options to resolve an unverified Card payment from your account. If you have a Card transaction that requires verification, a link to the Card Use Verification Form will be prominently displayed when you access your account at https://participant.wageworks.com. The Card Use Verification Form includes a list of options to resolve an unverified payment from your account. Use this form to submit the actual receipt or a substitute receipt to show that this amount was used for eligible products and services or to submit a check to repay your account for this amount.

Full-Purpose Health Care FSA and Limited Dental/Vision FSA questions, denied reimbursement, and appeals

If you have a question or concern about a Full-Purpose Health Care FSA claim or a Limited Dental/Vision FSA claim processed by HealthEquity, you may call HealthEquity (see the "Contacts" section on page 5-2).

If your claim was denied (in whole or in part), you may also file a formal written appeal with HealthEquity under the terms of the Health Care FSA Plan. If you call HealthEquity, your call will not be considered a formal appeal under the terms of the Health Care FSA Plan. A formal written appeal must be filed with HealthEquity within 180 days of the date your claim is denied regardless of any verbal discussions that have occurred regarding your claim. More detailed information on Full-Purpose Health Care FSA and Limited Dental/Vision FSA appeals is provided in "Appendix A: Claims and Appeals."

Chapter 6: Day Care Flexible Spending Account

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Contacts

Information about the Day Care Flexible Spending Account	HealthEquity 1-877-924-3967 HR Services & Support site
To file claims online, view account information and activity, or find forms	https://participant.wageworks.com Access from HR Services & Support site.
To fax claim forms toll-free	1-877-353-9236
Information about enrollment	Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.

This chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More" and the "Plan information," "Participating employers," and "Future of the plans" sections of "Appendix B: Important Notifications and Disclosures" — contains information applicable to the Wells Fargo & Company Day Care Flexible Spending Account (the Day Care FSA). The Day Care FSA is not subject to or governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The basics

Introduction

The Day Care FSA is sponsored by Wells Fargo & Company, and is administered by HealthEquity. The Day Care FSA allows you to set aside money on a before-tax basis to pay for eligible day care expenses associated with caring for your children under the age of 13, or elderly or disabled dependents whom you claim as tax dependents. It is important for you to understand that the Day Care FSA cannot be used for health care expenses (including medical, dental, and vision expenses). Your decision to participate in this voluntary account should be based on your needs and personal situation. It is also important that you understand the limitations of a Day Care FSA before you decide whether to participate (see the "Day Care FSA rules" section starting on this page). Be sure to read this chapter carefully before enrolling in a Day Care FSA.

You may contribute from $130 to $5,000 annually to the Day Care FSA, subject to limitations imposed by applicable law and IRS guidance. For example, highly compensated employees, as defined by applicable IRS guidance, may only contribute up to $2,500. For more information, see the "Contribution limits" section on page 6-6.

The Day Care FSA can reimburse you for eligible day care expenses that are incurred to enable you (and your spouse if you are married) to be gainfully employed or to look for work. You may be able to use the Day Care FSA if:

- You are a single parent.
- You are married and your spouse works outside the home or telecommutes, is actively looking for work, is a full-time student, or is mentally or physically incapable of self-care.

The information provided in this chapter is not intended to provide tax advice for any individual's specific situation. If you have any questions regarding the tax implications surrounding your specific situation, including questions about whether the dependent care tax credit or Day Care FSA is more favorable to you, please consult a tax advisor.

Note: Any balance remaining in your Day Care FSA after eligible expenses have been submitted and reimbursed by the filing deadline will be forfeited and cannot be rolled over or paid out to you. For more information on the claims filing deadline, see the "Claims filing time frame" section on page 6-10.

Claims administrator

HealthEquity is the claims administrator and processes requests for reimbursement from the Day Care FSA, which is not subject to ERISA. HealthEquity shall have the sole and discretionary authority to determine claims and requests for review in accordance with the terms of the documents or instruments governing the Day Care FSA.

Reimbursements

The Day Care FSA is a bookkeeping account established to keep track of your contributions and reimbursements. Except as required by law, amounts credited to the Day Care FSA remain the property of Wells Fargo & Company until reimbursed to the participant. Although this chapter refers to payroll deductions and contributions that are set aside, these deductions and contributions reflect pay reductions that you authorize with the understanding that all such deductions and contributions are held as, and reimbursements are paid from, Wells Fargo & Company's general assets. No specific assets are set aside or otherwise segregated from Wells Fargo & Company's general assets for the reimbursements.

Who's eligible

You are eligible to enroll in the Day Care FSA if you are a regular or fixed term employee as described in the "Eligible employees" section in "Chapter 1: Eligibility, Enrollment, and More."

Note: Interns and flexible employees are not eligible to enroll in the Day Care FSA.

Day Care FSA rules

Your contributions to, and reimbursements from, the Day Care FSA are designed to qualify for favorable tax treatment by the IRS. In exchange for these potential tax advantages, the IRS imposes strict rules about how you may use your Day Care FSA. Before enrolling, consider the rules described below and the rest of the information in this chapter. Please note the information provided in this chapter is not intended to provide tax advice for any individual's specific situation. If you have any questions regarding the tax implications surrounding your specific situation, please consult with a tax advisor.

Note: For the purposes of the Day Care FSA, the "plan year" is the same as a calendar year, beginning on January 1 and ending the following December 31.

- The Day Care FSA, also known as a dependent care account, can be used to pay for eligible day care expenses for children under the age of 13, or elderly or disabled dependents whom you claim as tax dependents.
- Money set aside for the Day Care FSA cannot be used to pay for health care expenses (including medical, dental, and vision expenses).

- You cannot transfer your Day Care FSA balance to any other flexible spending account, including a Full-Purpose FSA or Limited Dental/Vision FSA under the Wells Fargo & Company Health Care Flexible Spending Account Plan.
- You may not use the Day Care FSA and request tax credits for the same expenses. When you file your tax returns, you cannot deduct or claim a tax credit for expenses paid by the Day Care FSA.
- You must use the money in your Day Care FSA for eligible day care expenses that are incurred (1) in the same year you contribute the money or during the grace period described below, and (2) while you are a participant in the Day Care FSA. You cannot be reimbursed for day care expenses incurred before your participation begins or after your participation ends.
- If you are enrolled in the Day Care FSA on December 31 of a plan year and have not exhausted your balance, you qualify for a grace period — January 1 through March 15 of the year following the plan year. (There was an extended grace period for the 2021 and 2022 plan years, as described below.) This grace period extends the time period during which you can incur eligible expenses. Eligible expenses incurred during the grace period that are eligible for reimbursement will be reimbursed from the prior plan year's balance until that balance is exhausted. If you are also participating in the Day Care FSA during the plan year in which the expenses are incurred, then any eligible expenses that are not paid from the prior plan year's balance may be eligible to be paid from the current plan year's balance.

  For example, you are a participant in the Day Care FSA on December 31, 2021, you incur $100 worth of eligible day care expenses on January 15, 2022, and you submit a request for reimbursement on January 30, 2022. At that time, you have a $50 balance still remaining in your 2021 Day Care FSA. Accordingly, $50 of your $100 eligible day care expenses will be reimbursed to you from your 2021 account and the remaining $50 may be eligible to be reimbursed from your 2022 account if you have elected the Day Care FSA for 2022.
- You must submit completed claims to HealthEquity by April 30 of the year following the plan year. The claim must include proper expense documentation for eligible day care expenses incurred during the plan year or during the applicable grace period. To ensure that your claims are complete by this date, submit your initial claims early in case you are asked for additional information or are missing any items. Claims or expense documentation submitted after the April 30 deadline will not be reimbursed. A completed claim consists of a signed Pay Me Back claim form and required documentation, as determined by HealthEquity.
- If the April 30 claims submission deadline has passed and you have a remaining balance from the previous plan year, the previous plan year's balance is forfeited and you no longer have the opportunity to request additional reimbursements from that previous year's balance. You cannot receive a refund for the unused balance.
- A Day Care FSA expense is incurred when the day care service is received, not when you pay the provider. For example, if you pay for day care services in advance, you cannot receive reimbursement for those expenses until after the services have been provided.
- After you enroll in the Day Care FSA, you may not increase or decrease your elected contributions unless you have a day care-related Qualified Event. For more information, see the "Changing coverage" and the "Qualified Events" sections in "Chapter 1: Eligibility, Enrollment, and More."
- If your pay is not sufficient to cover your per pay period contributions or your contributions are otherwise missed and you owe any back contributions, you will experience double deductions until all missed contributions have been taken, or the last paycheck of the year, whichever comes first. For more information on arrears, see the "Paying for coverage" section in "Chapter 1: Eligibility, Enrollment, and More."
- If you experience a day care-related Qualified Event and you elect to increase your annual contributions, claims against the increased annual contribution amount must be incurred on, or after, the effective date of the newly elected annual contribution amount. Your new per-pay-period contribution amount will be calculated by subtracting your year-to-date contributions from your newly elected annual contribution amount and dividing the difference by the number of pay periods remaining for the plan year.

  For example:

  – Your original annual contribution for the Day Care FSA is $2,000, elected during Annual Benefits Enrollment.

  – Assuming 26 pay periods per plan year results in a $76.92 contribution per pay period.

  – A day care-related Qualified Event occurs on September 4.

  – You make your Day Care FSA election change on September 10 in Workday and elect to increase your annual contribution to $3,500 for the plan year.

  – The effective date for your increased annual elected contribution is October 1. Assuming there have already been 20 pay periods under your prior election, your per-pay-period contributions will be increased from $76.92 to $326.92 for the remainder of the plan year ($3,500 minus $1,538.46 collected in the prior 20 pay periods leaves $1,961.54 to be divided between the remaining six pay periods).

  – You may only be reimbursed up to the amount you have contributed in the first 20 pay periods ($1,538.46) before the effective date of the increased contribution amount for eligible expenses incurred before October 1. However, if you have not incurred $1,538.46 worth of eligible expenses by October 1, you can continue to incur eligible expenses during the remainder of the plan year and the applicable grace period. Eligible expenses incurred from October 1 through the end of the plan year (and during the applicable grace period) cannot exceed the difference between your increased election of $3,500 less the amount of any reimbursements for eligible expenses incurred prior to October 1.

- If you experience a day care-related Qualified Event and you elect to drop your participation in the Day Care FSA, your annual contribution will be adjusted to the amount you have already contributed up to the date your participation in the Day Care FSA ends. You may only file claims for eligible expenses incurred before your participation ends.
- If you experience a day care-related Qualified Event and you elect to decrease your annual contributions but want to continue your participation in the Day Care FSA, you may not elect to decrease your annual contribution below the amount you have already contributed up to the date the change in your contributions is effective. Your reduced annual contribution is also subject to a minimum per-pay-period contribution of $5.00 to continue your participation. Continuing your participation allows you to continue to file claims for eligible expenses incurred after the effective date of the change in your contributions. If you experience a day care-related Qualified Event and you elect to decrease your annual contribution, your reimbursement for eligible expenses is limited to the new reduced annual contribution amount. Your new per-pay-period contribution amount will be calculated by subtracting your year-to-date contributions from your new annual contribution amount and dividing the difference by the number of pay periods remaining for the plan year.

  For example:

  – Your original annual contribution for the Day Care FSA is $2,000, elected during Annual Benefits Enrollment.
  – Assuming 26 pay periods per plan year results in a $76.92 contribution per pay period.
  – A day care-related Qualified Event occurs on September 4.
  – You make your Day Care FSA election change on September 10 in Workday and elect to decrease your annual contribution to $1,850 for the plan year.
  – The effective date for your decreased annual elected contribution is October 1. Assuming there have already been 20 pay periods under your prior election, your per-pay-period contributions will be decreased from $76.92 to $51.92 for the remainder of the plan year ($1,850 minus $1,538.46 collected in the prior 20 pay periods leaves $311.54 to be divided between the remaining six pay periods).
  – You may only be reimbursed up to $1,850 for expenses incurred for the entire plan year.
- If you are rehired in the same year in which you terminated employment with Wells Fargo or if you return to a regular or fixed term position during the same year that you moved to ineligible status and elect to participate in the Day Care FSA both prior to termination or moving to ineligible status and after your rehire or return to a regular or fixed term position, both periods are separate and distinct periods.

  Note: Your election amount after your rehire or return to a regular or fixed term position will be limited to the annual contribution limit minus any Day Care FSA payroll contributions taken prior to your previous termination or move to ineligible status so that you do not exceed the applicable contribution limit for the plan year. See the "Contribution limits" section on page 6-6.

  For example:

  – Your original annual contribution for the Day Care FSA is $2,000, elected during Annual Benefits Enrollment.
  – Assuming 26 pay periods per plan year results in a $76.92 contribution per pay period.
  – Your employment with Wells Fargo is terminated on March 15.
  – You may only be reimbursed up to $461.54 (assuming six pay periods and a $76.92 per-pay-period contribution) for expenses incurred before March 15 since this is all that you contributed for the plan year.
  – You are rehired on August 15 with coverage effective October 1 (the first of the month after one full calendar month of service). You are eligible to elect $4,538.46 ($5,000 annual limit minus $461.54 taken in previous payroll deductions), unless you are a highly compensated employee, in which case you are eligible to elect $2,038.46 ($2,500 annual limit minus $461.54 taken in previous payroll deductions). However, you elected a $1,200 Day Care FSA annual contribution amount (assuming six pay periods remain in the plan year results in a $200 contribution per pay period).
  – You may only be reimbursed up to $1,200 for expenses incurred between October 1 and the end of the plan year, including the grace period.
- You are not permitted to enroll for COBRA continuation coverage to extend your participation in the Day Care FSA.

Your contributions

Your contribution amount

If you enroll in a Day Care FSA, your before-tax pay will be reduced each pay period by the per-pay-period contribution amount elected. Your elected annual contribution amount will be divided by the number of eligible pay periods in the calendar year. If you enroll midyear because you are newly hired, rehired, newly eligible, or experience a day care-related Qualified Event, your elected annual contribution amount will be divided by the number of eligible pay periods remaining in the plan year. See the "Day Care FSA rules" section starting on page 6-3 if you experience a midyear day care-related Qualified Event that impacts your annual contribution.

You can authorize contributions in any amount with a:

- Minimum of $130 per plan year or $5.00 per pay period.
- Maximum of $5,000 per plan year, subject to limitations imposed by applicable IRS guidance. Certain employees may be subject to a lower contribution limit. See the "Contribution limits" section on this page.

The Day Care FSA is a bookkeeping account established to keep track of your contributions and reimbursements. Except as otherwise required by law, amounts credited to the Day Care FSA remain the property of Wells Fargo & Company until reimbursed to participants. When you participate in the Day Care FSA, your account is credited as you make per-pay-period contributions. This means that your current balance equals your actual contributions made to date, less any reimbursements. You may only receive reimbursement up to the amount of your current balance.

Contribution limits

In general, participants may contribute up to $5,000 on a before-tax basis to a Day Care FSA. However, the IRS has established other limitations on your before-tax Day Care FSA reimbursements in addition to the $5,000 annual contribution maximum, as described in the table below. Total annual contributions generally cannot exceed the amount of your pay for the plan year.

If your spouse also participates in a dependent care assistance program where they work, the total amount reimbursed on a before-tax basis in both your Day Care FSA and your spouse's dependent care assistance program cannot exceed $5,000 per year, subject to the other limitations imposed by applicable IRS guidance. You and your spouse cannot claim the same expenses. Please consult a tax advisor for further information.

Note for highly compensated employees (HCEs): The IRS allows pretax contributions to the Day Care FSA as long as the FSA does not discriminate in favor of HCEs (as defined by applicable IRS guidance). The Day Care FSA must pass nondiscrimination tests for benefits to be excluded from an employee's gross income. If the Day Care FSA fails testing, HCEs will be taxed on the dependent care benefits they received. To help reduce the possibility of nondiscrimination testing failures, Wells Fargo sets the annual contribution limit at $2,500 for employees considered to be HCEs. Non-highly compensated employees are not affected by this rule (e.g., their Day Care FSA election would continue to be excluded from gross income even if there was a nondiscrimination testing failure).

If you are:	The following IRS limit on before-tax reimbursements will apply:
Single	The lesser of: • $5,000 • Your earned income
Married and file a joint tax return	The lesser of: • $5,000 • Your earned income • Your spouse's earned income (if you're married at the end of the tax year)
Married and file separate tax returns	The lesser of: • $2,500 • Your earned income • Your spouse's earned income (if you're married at the end of the tax year)
Married with spouse who is either: • **Physically or mentally incapable of self-care** • **A full-time student at least five months a year**	• For one dependent: $250 for each month your spouse is disabled or a full-time student, to a maximum of $3,000 per year • For two or more dependents: $500 for each month your spouse is disabled or a full-time student, up to $5,000 per year

How to enroll

New hire and employment classification change enrollment

If you are eligible, you may enroll in the Day Care FSA in Workday, at work or at home, or by calling Employee Care during your designated enrollment period. For more information, see the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

If you enroll during your designated enrollment period, your participation begins on the first of the month following one full calendar month of service in a regular or fixed term position. If you enroll, you must participate for the remainder of the plan year (calendar year) unless you have a Qualified Event that permits dropping coverage. For more information, see the "Changing coverage" section in "Chapter 1: Eligibility, Enrollment, and More."

If you don't enroll during your initial designated enrollment period, you cannot elect to participate in the Day Care FSA until the first day of the plan year following the next Annual Benefits Enrollment period, unless you experience a day care-related Qualified Event that permits you to make a midyear election. For more information, see the "Changing coverage" and the "Qualified Events" sections in "Chapter 1: Eligibility, Enrollment, and More."

Annual Benefits Enrollment

Participation in the Day Care FSA does not continue automatically from year to year. You must make an affirmative annual contribution election during the Annual Benefits Enrollment period to participate in the Day Care FSA for the following plan year. You may also elect to increase or decrease your annual contribution each plan year, subject to applicable contribution limits, or choose not to reenroll during the Annual Benefits Enrollment period.

Rehire or return to a regular or fixed term position

If you are an eligible rehired employee, or you return to a regular or fixed term position, and you want to participate in the Day Care FSA, you must reenroll during your designated enrollment period as described under the "New hire and employment classification change enrollment" section on this page. In addition, your election amount after your rehire or return to a regular or fixed term position will be limited to the annual contribution limit minus any Day Care FSA payroll contributions taken prior to your previous termination or change in employment classification to an intern or flexible position so that you do not exceed the applicable contribution limit for the plan year. See the "Day Care FSA rules" section starting on page 6-3 for more information relating to your Day Care FSA after a rehire or return to a regular or fixed term position.

Changing participation

Changes are restricted

IRS regulations restrict your ability to change your contributions to the Day Care FSA during the plan year. You cannot change your contribution amount to your Day Care FSA during the plan year unless you have experienced a day care-related Qualified Event.

For more information, see the "Changing coverage" and the "Qualified Events" sections in "Chapter 1: Eligibility, Enrollment, and More," and the "Leave of absence" section starting on this page.

For more information on how a change in contributions, as a result of a Qualified Event, may impact the Day Care FSA see the "Day Care FSA rules" section starting on page 6-3.

Employment classification change

If you begin participating in the Day Care FSA and then your employment classification changes from a regular or fixed term position to an intern or flexible position, you are no longer eligible to participate in the Day Care FSA. Your Day Care FSA contributions stop after the change in employment classification is processed. You may, however, still submit claims for eligible expenses incurred up to the date your employment classification changed to an intern or flexible position. However, your total reimbursement is limited to actual year-to-date contributions made. You may not continue participation in the Day Care FSA under COBRA.

Leave of absence

Contributions

Refer to "Appendix D: Leaves of Absence and Your Benefits" for information on making contributions to the Day Care FSA while you are on an approved leave of absence.

Note: Taking an approved leave of absence is a day care-related Qualified Event allowing you to revoke your Day Care FSA election. If you want to revoke your election as a result of this event, access Workday or call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days of the event to make your revocation. The effective date of change is the first of the month following the event or the first of the month following your election change, whichever is later.

When you return from a leave of absence during the same plan year in which your leave began:

- If you return to work from leave in a regular or fixed term position in the same plan year during which your leave began, you continued to make contributions to your Day Care FSA while on your approved leave, and you did not miss any contributions, your contributions will continue at the same rate for the rest of the plan year.

- If you return to work from leave in a regular or fixed term position in the same plan year during which your leave began, you did not revoke your participation in the Day Care FSA as a result of your leave, but contributions ceased while you were on leave because you did not have a sufficient recognized source of income to allow for deductions, your contributions automatically resume when you return to work. Missed contributions will go into arrears and be deducted from future paychecks. For more information on arrears, see the "Paying for coverage" section in "Chapter 1: Eligibility, Enrollment, and More."
- If you revoked your Day Care FSA election when you began your approved leave of absence and you return to work in a regular or fixed term position during the same plan year, your return to work is a day care-related Qualified Event and you may reenroll in the Day Care FSA by accessing Workday or calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days of your return to work in a regular or fixed term position. Your participation and deductions will begin again the first of the month after you make your election change by accessing Workday or calling Employee Care to request reenrollment.
- If you or Wells Fargo revoked your Day Care FSA election while you were on an approved leave of absence and you return to work in a regular or fixed term position during the same plan year, your return to work is a day care-related Qualified Event and you may reenroll in the Day Care FSA by accessing Workday within 60 days of returning to work. Your participation and deductions will begin again the first of the month you make your election change by accessing Workday to request reenrollment.

When you return from a leave of absence in a subsequent plan year:

- If you return to work from an approved leave of absence in a subsequent plan year, your contributions for the plan year in which you began your leave will not be adjusted to make up for contributions that were missed while you were on leave. Your Day Care FSA annual contribution for the plan year in which you began your leave will be equal to the total amount that you actually contributed to the Day Care FSA during that plan year.
- If you revoked your Day Care FSA election when you began your approved leave of absence and you return to work in a regular or fixed term position in the subsequent plan year:
  - If you made an Annual Benefits Enrollment election for the Day Care FSA and are on an approved leave of absence on January 1, refer to the "Annual Benefits Enrollment while on leave" section on this page.
  - If you did not make an Annual Benefits Enrollment election for the Day Care FSA while you were on an approved leave, your return to work is a day care-related Qualified Event and you may reenroll in the Day Care FSA by accessing Workday or calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days of returning to work. Your participation and deductions will begin again the first of the month after you make your election change by accessing Workday or calling Employee Care to request reenrollment.

Claims

If you participate in the Day Care FSA, generally, you cannot claim expenses incurred during your leave. To be eligible for reimbursement under the Day Care FSA, the day care expenses must be incurred so you can work or look for work.

Annual Benefits Enrollment while on leave

You may make an Annual Benefits Enrollment election for the Day Care FSA while you are on an approved leave of absence. However, if you are on a leave of absence on January 1, without recognized sources of income replacement, contributions will begin when you return to work in a regular or fixed term position. Missed contributions in arrears will also be deducted from future paychecks.

When participation ends

Participation in the Day Care FSA ends on the date that:

- Your last day of employment takes place.
- You no longer meet the eligibility requirements.
- You cancel participation, as permitted by Day Care FSA Plan provisions.
- You die.

Participation in the Day Care FSA will also end if the Day Care FSA Plan is discontinued or terminated regardless of any of the events noted above.*

* For more information on the Day Care FSA's amendment and termination procedures, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

You may continue to file claims for eligible expenses incurred before the date your participation ends until your available account balance is zero or until April 30 of the next calendar year, whichever occurs first. As noted previously, eligible expenses are incurred when the day care service is received and not when you pay the provider.

Example: If you start participating in the Day Care FSA at the beginning of the plan year and then terminate employment on May 15, you may file claims for eligible expenses incurred between January 1 and May 15. You have until April 30 of the next calendar year to submit these claims.

If you have provided fraudulent information regarding the Day Care FSA (or otherwise committed fraud with respect to the Day Care FSA), your participation in the Day Care FSA may be terminated (or you may not be permitted to participate in the Day Care FSA).

COBRA coverage

Continuation coverage under COBRA is not available for the Day Care FSA.

If you die

If you die, your surviving spouse or domestic partner, executor of your estate, or legal representative may continue to file claims for eligible expenses incurred while you were a participant in the Day Care FSA until your applicable account balances are used up or the final claim deadline, whichever occurs first. The death certificate and appropriate legal documentation will need to be provided. Continuation coverage under COBRA is not available for the Day Care FSA.

Using the Day Care FSA

General information

The Day Care FSA can reimburse you for expenses that are incurred to enable you (and your spouse if you are married) to be gainfully employed or to look for work. You may be able to use the Day Care FSA if:

- You are a single parent
- You are married and your spouse works outside the home, is looking for work, is a full-time student, or is mentally or physically incapable of self-care

Using your Day Care FSA dollars

Option:	Best used when:	Additional details can be found:
Pay My Provider	You want to schedule automatic payments to your day care provider for eligible expenses from available funds in the Day Care FSA	"Pay My Provider (PMP) payment option" section on page 6-11
Pay Me Back	You paid the day care provider with your personal funds and want to be reimbursed for the eligible expense from available funds in the Day Care FSA	"Filing a claim" section starting on page 6-10

Eligible dependents

You can authorize contributions to the Day Care FSA to reimburse eligible expenses for:

- Children under age 13 for whom you or your spouse are eligible to claim a federal income tax exemption (that is, a "qualifying child"). Your domestic partner's children may not meet the requirements to be your qualifying child. Consult a tax advisor for further information.
- Your spouse who is physically or mentally incapable of self-care and who has the same principal residence as you for more than half of the plan year. For purposes of the Day Care FSA, your spouse is the individual to whom you are legally married and who is recognized as your spouse under federal law, but does not include an individual separated from you under a legal separation decree.
- Your other dependents, such as a qualifying child or a qualifying relative, if that person is physically or mentally incapable of self-care, has the same principal place of residence as you for more than half of the year, and for whom you can claim (or could claim) a federal income tax exemption.

Different rules may apply if you are divorced or legally separated. Consult a tax advisor.

Eligible Day Care FSA expenses

The Day Care FSA covers only eligible day care expenses, not health care expenses. To be eligible, you must incur these day care-related expenses for the care of an eligible dependent (see above) so you (and your spouse if you are married) can work or look for work. Payments for the following are generally eligible expenses:

- Care providers inside or outside your home
- Day care provided at a licensed nursery school, day care center, or day camp (including summer day camp) in compliance with applicable state and local laws
- Before- or after-school programs
- Any other expenses that would be considered eligible for a dependent care credit for federal income tax purposes

Note: An expense is incurred when the service is received, not when a payment for that service is made.

Ineligible Day Care FSA expenses

The Day Care FSA does not pay certain expenses, including:

- Child support payments
- Claims filed after the claims filing deadline
- Education expenses (for example, tuition for kindergarten, primary school, or secondary school)
- Expenses incurred after the Day Care FSA ends or your participation in the Day Care FSA ends
- Expenses incurred before your effective date of participation in the Day Care FSA
- Health care expenses (including medical, dental, and vision expenses)
- Payments to your spouse, your child under age 19 (whether a dependent or not), or other dependent for taking care of your children
- Personal expenses for dependents, such as the cost of clothing and meals
- Overnight camp

- Any expenses you claim for the dependent care tax credit on your federal income tax return
- Other expenses not permitted to be reimbursed by applicable law or IRS guidance

However, you can submit claims for nursery school care that includes some meals or educational activities if they cannot be separated from the cost of care, or household services that include caretaking services for one or more eligible dependents.

Claims and requests for review

HealthEquity is the claims administrator and processes requests for reimbursement from the Day Care FSA. HealthEquity has the sole and complete discretionary authority to determine claims and requests for review in accordance with the terms of the documents or instruments governing the Day Care FSA. Procedures for filing claims under the Day Care FSA are set forth below, as are review requests for the Day Care FSA if a claim has been denied.

Filing a claim

To be reimbursed for an eligible expense from the Day Care FSA, submit a completed and signed Pay Me Back claim form with required documentation to the claims administrator, HealthEquity. The claim form is available to you on the HealthEquity website at https://participant.wageworks.com. You may file your claim by one of the methods noted below:

- Using the website, you can complete an online claim form at https://participant.wageworks.com, and upload your scanned supporting expense documentation for your claim submission.
- You can use the HealthEquity mobile app. It's a quick and easy way to submit claims and receipts. This app should be used on personal devices only and should not be used on Wells Fargo owned devices.
- Fax the completed and signed claim form, along with all required supporting expense documentation, to HealthEquity at 1-877-353-9236 (keep a copy of the faxed documentation and the fax confirmation).
- Scan the completed and signed claim form, along with all required supporting expense documentation, and upload through https://participant.wageworks.com.
- Mail the completed and signed form, along with all required supporting expense documentation, to:

  Claims Administrator — HealthEquity
  PO Box 14053
  Lexington, KY 40512

See the "Required expense documentation" section on this page for more information.

Claims filing time frame

In general, claims for expenses incurred during a plan year, and applicable grace period, must be postmarked, faxed, or electronically filed as explained above by April 30 of the year immediately following the plan year. You can file a claim as soon as you have incurred an eligible expense, or you can accumulate your expenses and file them together at the same time. You may submit claims only for expenses incurred while you were a Day Care FSA participant.

If following the April 30 deadline, you have a remaining balance in your Day Care FSA after all eligible expenses for the prior plan year have been reimbursed, your remaining balance will be forfeited and you will lose the opportunity to request additional reimbursements from this balance. For example, if you have not filed for reimbursement of your eligible expenses from your 2022 Day Care FSA by April 30, 2023, any remaining 2022 funds will be forfeited. Forfeited balances will remain the property of Wells Fargo & Company and may be used for any purpose permitted by applicable law. You cannot receive a refund for the unused balance.

Special Grace Period Rules for 2020 and 2021 Plan Years

In response to the COVID-19 pandemic and as allowed by the Consolidated Appropriations Act, the grace period for incurring and filing Day Care FSA claims was extended for the 2020 and 2021 plan years as described below.

Day Care FSA – 2020 grace period extended. If you were enrolled in the Day Care FSA on December 31, 2020, and did not exhaust your 2020 balance, you qualify for a grace period. This grace period gives you additional time to use 2020 contributions by allowing you to use them on eligible expenses incurred in 2021. The Day Care FSA grace period for the 2020 plan year was originally scheduled to run from January 1, 2021 – March 15, 2021, and is now extended to run from January 1, 2021 – December 31, 2021. **Note:** You now have until April 30, 2022, to file a claim, along with required documentation, for reimbursement of expenses incurred in the 2020 plan year and the associated grace period.

Day Care FSA – 2021 grace period extended. If you were enrolled in the Day Care FSA on December 31, 2021, and did not exhaust your 2021 balance, you qualify for a grace period. This extension of the grace period for the 2021 plan year gives you additional time to use 2021 contributions by allowing you to use them on eligible expenses incurred in 2022. The Day Care FSA grace period for the 2021 plan year would typically run from January 1, 2022 – March 15, 2022. The extension of the Day Care FSA grace period allows you to incur additional expenses between January 1, 2022 – December 31, 2022. **Note:** You have until April 30, 2023, to file a claim, along with required documentation, for reimbursement of expenses incurred in the 2021 plan year and the associated grace period.

Required expense documentation

Required documentation may include the following, as determined by HealthEquity:

- If your provider does not sign the claim form, you must submit a receipt that includes the:
  1. Provider's name
  2. Dates of service
  3. Description of service provided
  4. Eligible dependent's name
  5. Amount charged

  Handwritten receipts must include either a tax identification number, signature, or stamp from the facility. Balance due statements, general statements of account, credit card receipts, cash register receipts, or canceled checks are not acceptable forms of documentation.
- If you are submitting a claim for day care expenses associated with kindergarten, primary school, or secondary school, you must submit an itemized bill separating tuition expenses from eligible day care expenses. You must include the:
  1. Provider's name
  2. Dates of service
  3. Description of service provided
  4. Eligible dependent's name
  5. Amount charged

  Balance due statements, general statements of account, credit card receipts, cash register receipts, or canceled checks are not acceptable forms of documentation.

Keep copies of all documentation submitted. If you fax your documentation, keep a copy of the faxed documentation and the fax confirmation for your records.

Claim payment

Your eligible claims will be paid up to your current account balance. For the Day Care FSA, your "current account balance" is the amount of contributions you have actually made to date at any point during the plan year, less any claims paid. (Claims that cannot be paid in full because of insufficient funds will not be reimbursed until further contributions sufficient to reimburse the total amount of such claims are received.)

You will be reimbursed for claims the same way you receive your Wells Fargo pay. If you receive your pay by direct deposit, your reimbursement will be deposited to the same account (if you have more than one direct deposit account, your reimbursement will be deposited into the balance account). If you receive your pay by check, you'll receive your reimbursement by check.

Note: If you are not enrolled in an FSA in the current year and are submitting claims incurred during the grace period for your prior year balance, you will be reimbursed by check.

After your claim for reimbursement has been processed, you will receive your reimbursement with an explanation of your benefit. If you have entered your preferred email address on the HealthEquity website, your Explanation of Benefits will be sent via email. Otherwise, you will receive a hard copy in the mail.

The minimum claim payment is $25. Claims will not be paid until they total at least $25 (except for the final claim payment for the plan year).

Ineligible payments or reimbursements

If it is determined that a participant has received reimbursements from the Day Care FSA that exceed the amount of eligible expenses substantiated by the participant, or if reimbursements have been made in error, the participant must repay the Day Care FSA an amount equal to the excess reimbursement. If the participant fails to repay the amount of the excess reimbursement, future reimbursements from the Day Care FSA may be offset or collection proceedings to recover excess reimbursements may be initiated.

Account activity and status

Access your account online to review and print your real-time account information at any time of the day or month. Your account activity and status includes information about:

- Your current and available funds
- Ineligible payments or your recent payments, claims, and reimbursements
- Special messages about your account

Make sure you review your account activity and status thoroughly.

If you have entered your preferred email address on the HealthEquity website, HealthEquity will provide you with critical, activity-based email alerts, such as your claims payment information. You will be able to check your balance 24 hours a day, 7 days a week by accessing your account at https://participant.wageworks.com or by calling HealthEquity at 1-877-924-3967.

Pay My Provider (PMP) payment option

Pay My Provider (PMP) gives you the ability to have HealthEquity make a payment directly from the Day Care FSA to your provider for eligible expenses for Day Care FSA transactions. You can request a one-time or recurring payment. You can set up a PMP payment (similar to online bill pay with your personal checking account) to come directly out of your Day Care FSA. An itemized invoice or other appropriate proof of service is required before PMP payments can be issued. The invoice or other documentation must include the dates of service, type of service, service provider, dependent's name, and cost of service. The payment request will remain open in the system until the documentation is submitted. One-time requests will be processed and distributed just a few days after the submitted invoice or documentation has been approved. You are permitted to enter a requested payment date that is up to 10 calendar days before the due date shown on the contract, if required. A one-time payment cannot be canceled once it is submitted. A recurring payment, however, may be canceled up to 10 days before the requested payment date.

To request a PMP payment, sign on to https://participant.wageworks.com, and follow the necessary prompts to submit (mail, fax, or scan and upload) your itemized invoice or other appropriate documentation to complete your Pay My Provider request.

Day Care FSA claim questions, denied reimbursement, and requests for review

If you have a question or concern about a claim processed by the claims administrator, HealthEquity, you may call HealthEquity (see the "Contacts" section on page 6-2).

Day Care FSA claims are not governed by the ERISA claims and appeals provisions set forth in "Appendix A: Claims and Appeals." If you are dissatisfied with the processing of your Day Care FSA claim, you may submit a written request for review to HealthEquity within 180 days of the date the claim was processed. If your request is not submitted within this time period, it will not be reviewed. Submit a letter explaining the reason you believe the day care expense should be reimbursable under the terms of the Day Care FSA and any documentation that supports your request. Although the request for review is not governed by the appeal provisions, the request for review should be submitted to:

HealthEquity Claims
Appeal Board
PO Box 34700
Louisville, KY 40232

HealthEquity will review your request and issue the final determination to you.

Chapter 7: Life Insurance Plan

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Contacts

Information about life insurance provisions	HR Services & Support site
Information about premiums for life insurance	HR Services & Support site
Questions about current coverage, enrollment, or to file a claim	Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.
To check status on your submitted Statement of Health or filed claim	Metropolitan Life Insurance Company (“MetLife”) 1-866-549-2320
Information about portability enrollment and filing a claim for portability coverage (includes Minnesota continuation for Minnesota residents)	Metropolitan Life Insurance Company (“MetLife”) 1-866-549-2320
Information about conversion enrollment and filing a claim for conversion coverage	Metropolitan Life Insurance Company (“MetLife”) 1-866-549-2320
Information about retiree continuation enrollment and filing a claim for retiree continuation coverage	Metropolitan Life Insurance Company (“MetLife”) 1-866-549-2320

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Important Notifications and Disclosures," and "Appendix D: Leaves of Absence and Your Benefits" — constitutes the Summary Plan Description (SPD) for the life insurance coverage available to regular and fixed term employees and their eligible dependents under the Wells Fargo & Company Life Insurance Plan (the Life Insurance Plan).

The basics

General information

The Life Insurance Plan offers four types of term life insurance coverage:

- Basic Term Life
- Optional Term Life
- Spouse/Partner Optional Term Life
- Dependent Term Life

Wells Fargo pays the premium for Basic Term Life coverage, so all regular and fixed term employees are automatically enrolled. To participate in one or more of the other term life insurance coverage options listed in the "Your life insurance coverage options at a glance" table starting on page 7-4, you'll need to actively enroll in each coverage option separately and pay the applicable premium. See the "Your life insurance coverage options at a glance" table starting on page 7-4 for important information about your term life insurance coverage options.

All four types of term life insurance coverage offered under the Life Insurance Plan are covered by one group term life insurance policy.

The SPD is a summary of provisions for the Life Insurance Plan and its underlying fully insured policy issued by Metropolitan Life Insurance Company ("MetLife") and the corresponding Certificate of Insurance ("certificate"). For further details, contact Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to request a copy of the certificate. Individual certificates are not available. The SPD and Group Policy Number 164933-1-G issued by MetLife, along with any applicable certificates, policy amendments, riders, and endorsements (collectively the "Group Policy"), constitute the official plan document for the Life Insurance Plan. If there are differences between the SPD and the Group Policy, the Group Policy governs your rights to benefits.

The Life Insurance Plan is a "welfare benefit plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Insurer and claims administrator

The Life Insurance Plan is insured by Metropolitan Life Insurance Company ("MetLife"). MetLife has the discretionary authority to administer claims and interpret benefits under the Life Insurance Plan and respective coverage options.

Your life insurance coverage options at a glance

	Life insurance on you		Life insurance on your spouse or domestic partner	Life insurance on your dependent children
	Basic Term Life	**Optional Term Life**	**Spouse/Partner Optional Term Life**	**Dependent Term Life**
Coverage targets[1]	1 × covered pay[2] Minimum plan benefit: $10,000 Maximum plan benefit: $50,000	1 to 10 × covered pay[2] Minimum plan benefit: $10,000 Maximum plan benefit: $3,000,000	You select coverage target in increments of $25,000 Minimum plan benefit: $25,000 Maximum plan benefit: $250,000	$20,000 per dependent child
Who pays the premium	Wells Fargo — you are automatically enrolled.	You — if you enroll.	You — if you enroll.	You — if you enroll.
Cost	None — Wells Fargo pays the full cost.	You pay a premium based on coverage elected, age, and tobacco-user and/or nicotine-user status.		You pay a set premium for all covered dependent children.
Insurer	MetLife			
Policy number	Group Policy: No. 164933-1-G			
Coverage type	Group term life insurance			
Who's eligible	Regular and fixed term employees, as defined in "Chapter 1: Eligibility, Enrollment, and More."		Your spouse or domestic partner, as defined in "Chapter 1: Eligibility, Enrollment, and More."	Your dependent child, as defined in "Chapter 1: Eligibility, Enrollment, and More."
Who's not eligible	Interns and flexible employees, as defined in "Chapter 1: Eligibility, Enrollment, and More."		The spouse or domestic partner of an intern or flexible employee. Your spouse or domestic partner who does not meet eligibility criteria, as defined in "Chapter 1: Eligibility, Enrollment, and More."	The dependent child of an intern or flexible employee or their spouse or domestic partner. Your child who does not meet the definition of dependent child, as defined in "Chapter 1: Eligibility, Enrollment, and More."
Beneficiary	Person, persons, trust, or institution that you designate.[3]		You are automatically the designated beneficiary of your spouse or domestic partner.	You are automatically the designated beneficiary of your dependent children.

1. For more information on coverage targets, see the "How to enroll" section starting on page 7-8. Depending on the coverage target elected, you may be required to complete the Statement of Health process. See the "Statement of Health" section starting on page 7-9 for more information.

2. See the "Covered pay" section starting on page 7-14 for more information on how covered pay, referred to as "salary" in the Benefits section of Workday, is determined.

3. See the "Beneficiaries" section starting on page 7-12 for more information on how benefits are paid if you fail to designate a beneficiary.

	Life insurance on you		Life insurance on your spouse or domestic partner	Life insurance on your dependent children
	Basic Term Life	**Optional Term Life**	**Spouse/Partner Optional Term Life**	**Dependent Term Life**
Coverage effective date	Generally, first of the month after one full calendar month of service from your date of hire or effective date of your employment classification change from intern or flexible to regular or fixed term, provided that you are actively at work on the day coverage is scheduled to begin. For more information: • See the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More" • See the "Delayed effective date" section on page 7-9 to understand the actively at work requirement	Generally, first of the month after one full calendar month of service from your date of hire or effective date of your employment classification change from intern or flexible to regular or fixed term, provided that you enrolled during your designated enrollment period and you are actively at work on the day coverage is scheduled to begin. For more information: • See the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More" • See the "Delayed effective date" section on page 7-9 to understand the actively at work requirement	Generally, first of the month after one full calendar month of service from your date of hire or effective date of your employment classification change from intern or flexible to regular or fixed term, provided that you enrolled your spouse or domestic partner, or dependent child during your designated enrollment period and the spouse or domestic partner, or dependent child is not confined on the day coverage is scheduled to begin and you are actively at work on the day coverage is scheduled to begin, with the exception of newborns. For more information: • See the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More" • See the "Delayed effective date" section on page 7-9 to understand the nonconfinement clause	
Late enrollment	There is no late enrollment since you automatically receive coverage.	Access Workday for late enrollment in Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage. Late enrollment for Optional Term Life and Spouse/Partner Optional Term Life requires you to complete the Statement of Health process. For more information, see the "Statement of Health" section on page 7-9. **Note:** If your late enrollment request is for Dependent Term Life coverage, a Statement of Health is not required. Coverage for Dependent Term Life is effective the first of the month following your election in Workday. Coverage for Optional Term Life and Spouse/Partner Optional Term Life is subject to approval by MetLife and is effective the first of the month after approval by MetLife, subject to the actively at work requirement and the nonconfinement clause, as applicable (see the "Delayed effective date" section on page 7-9 for more information).		

	Life insurance on you		Life insurance on your spouse or domestic partner	Life insurance on your dependent children
	Basic Term Life	**Optional Term Life**	**Spouse/Partner Optional Term Life**	**Dependent Term Life**
Decrease or cancel coverage anytime	You cannot decrease or cancel coverage since you automatically receive coverage.	For Optional Term Life or Spouse/Partner Optional Term Life, Access Workday to decrease or cancel coverage. Change is effective the first of the month after your election change in Workday. Coverage cannot be decreased or canceled retroactively.		Access Workday to cancel coverage. Cancellation is effective the first of the month after your election change in Workday. Coverage cannot be canceled retroactively. (No decreased coverage is available since there is only one coverage target.)
Increase coverage	You may not increase coverage.	Access Workday to request increased coverage under Optional Term Life or Spouse/Partner Optional Term Life. Requesting increased coverage requires you to complete the Statement of Health process. For more information, see the "Statement of Health" section starting on page 7-9. Coverage is subject to approval by MetLife and effective the first of the month after approval by MetLife, subject to the actively at work requirement and the nonconfinement clause, as applicable (see the "Delayed effective date" section on page 7-9 for more information).		Not applicable since there is only one coverage target.

	Life insurance on you		Life insurance on your spouse or domestic partner	Life insurance on your dependent children
	Basic Term Life	**Optional Term Life**	**Spouse/Partner Optional Term Life**	**Dependent Term Life**
Qualified Events	Not applicable since coverage is automatically provided.	Access Workday to enroll in or increase Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage within 60 days of the following Qualified Events or within 60 days of the date that you return from leave if the Qualified Event occurs while you are on a leave of absence: • Birth, adoption, or placement for adoption of a child. (This event also includes when you, your spouse, or domestic partner newly becomes the legal guardian, legal custodian, or foster parent for a child, or if you or your spouse or domestic partner has been newly identified as the parent of a child.) • Marriage or creation of a domestic partnership. However, if you have a domestic partnership, whether or not your domestic partner is enrolled in any of your Wells Fargo benefits, and then you subsequently marry your domestic partner, you cannot enroll in or increase coverage without providing a Statement of Health form for approval by MetLife because your previously existing domestic partner who becomes your spouse is not a newly eligible dependent. • Death of a spouse or domestic partner or child, legal separation, divorce, annulment, or dissolution of a domestic partnership. (These Qualified Events only apply for Optional Term Life coverage.) • Return from military leave (military leave does not include absences or leaves for military reserve duty training assignments). Enrollment is subject to the actively at work requirement and the nonconfinement clause, as applicable (see the "Delayed effective date" section on page 7-9 for more information). You may enroll in or increase your Optional Term Life or Spouse/Partner Optional Term Life for the amounts specified below without submitting a Statement of Health form. Any request over these amounts will require you to complete a Statement of Health form for approval by MetLife. For more information, see the "Statement of Health" section starting on page 7-9.		
		Enroll at 1 × covered pay or increase by 1 × covered pay, referred to as "salary" in the Benefits section of Workday, up to the plan maximum.	Enroll at $25,000 or increase by $25,000 up to the plan maximum.	Enroll.
Suicide exclusion	None			
Porting or conversion once your Wells Fargo coverage ends	Port to a group policy or convert to individual policy for Basic Term Life or Optional Term Life coverage. Learn more about portability and conversion, including portability rates, for life insurance by accessing metlife.com/wf.		Port to a group policy or convert to an individual policy in the event of your death or if your spouse, domestic partner, or child no longer meets the eligibility requirements. Learn more about portability and conversion, including portability rates, for life insurance by accessing metlife.com/wf.	
Coverage when you're not working (approved leave of absence)	Basic Term Life coverage will generally continue for a maximum of 24 months.	Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage will continue as long as you pay the premium. (See "Appendix D: Leaves of Absence and Your Benefits.")		

Who's eligible

Regular and fixed term Wells Fargo employees and their eligible dependents as described in Chapter 1: Eligibility, Enrollment, and More are eligible for coverage under the Life Insurance Plan. Eligible employees may be covered both as an employee under their own Wells Fargo life insurance coverage election and as a dependent under their spouse, domestic partner, or parent's Wells Fargo life insurance coverage election. Interns and flexible employees and their dependents are not eligible for coverage. Please see the "Your life insurance coverage options at a glance" table starting on page 7-4 for more information about eligibility for each life insurance coverage option.

How to enroll

Initial enrollment

Eligible regular and fixed term employees are automatically enrolled in Basic Term Life coverage. Basic Term Life coverage provides a benefit that is one times covered pay with a minimum plan benefit of $10,000 and a maximum plan benefit of $50,000. **Note:** Covered pay is referred to as "salary" in the Benefits section of Workday. Basic Term Life coverage is effective on the first of the month following one full calendar month of service in a regular or fixed term position, subject to the requirement that they be actively at work on their first day of coverage as described in the "Delayed effective date" section on page 7-9.

You may enroll in Optional Term Life coverage, Spouse/Partner Optional Term Life coverage, Dependent Term Life coverage, or any combination thereof during your designated initial enrollment period. To enroll, access Workday, at work or at home, during your designated initial enrollment period. For more information, see the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

If you enroll during the designated initial enrollment period, guarantee issue coverage becomes effective the first of the month following one full calendar month of service in a regular or fixed term position, subject to the following:

- Optional Term Life coverage is subject to the actively at work requirement as described in the "Delayed effective date" section on page 7-9.
- Spouse/Partner Optional Term Life coverage and Dependent Term Life coverage are subject to the actively at work requirement and the nonconfinement clause as described in the "Delayed effective date" section on page 7-9.

If you do not enroll during the designated initial enrollment period, you must follow the procedures described in the "Late enrollment" section on page 7-11.

Optional Term Life

You can enroll from one to ten times your covered pay with a minimum plan benefit of $10,000 and a maximum plan benefit of $3,000,000.

- Enrollment for one to four times your covered pay (guarantee issue amount) during your designated initial enrollment period does not require completion of the Statement of Health form.
- Enrollment for five to ten times your covered pay during your designated initial enrollment period requires you to provide a completed Statement of Health form for the amount above four times your covered pay and is subject to MetLife's underwriting guidelines, whether you enroll during initial enrollment or under late enrollment provisions. For more information, see the "Statement of Health" section starting on page 7-9.
- Optional Term Life coverage is subject to the requirement that you be actively at work on the first day of coverage as described in the "Delayed effective date" section on page 7-9.

Spouse/Partner Optional Term Life

You can enroll in coverage for your spouse or domestic partner in $25,000 increments up to $250,000.

- Enrollment at $25,000 (guarantee issue amount) during your designated initial enrollment period does not require completion of the Statement of Health form.
- Enrollment for coverage at $50,000 to $250,000 during your designated initial enrollment period requires your spouse or domestic partner to provide a completed Statement of Health form for approval by MetLife. For more information, see the "Statement of Health" section starting on this page.
- Spouse/Partner Optional Term Life coverage is subject to the actively at work requirement and the nonconfinement clause as described in the "Delayed effective date" section on this page.

Dependent Term Life

You can enroll in Dependent Term Life coverage for your eligible dependent children. You do not need to separately enroll each individual dependent child. Enrollment in Dependent Term Life coverage automatically covers all of your eligible dependent children as well as any future newly eligible dependent children (for more information about adding Dependent Term Life coverage at a future date, see the "Changing coverage" section starting on page 7-10), as long as you remain enrolled in the Dependent Term Life coverage. Each enrolled eligible dependent child will have $20,000 in coverage.

A dependent child can be covered under Dependent Life Insurance of more than one employee if both parents work for Wells Fargo.

Dependent Term Life coverage is subject to the actively at work requirement and the nonconfinement clause, with the exception of newborns (see the "Delayed effective date" section on this page for more information).

Your dependent child's eligibility will be verified at the time a claim is filed, and the claim will be denied if your dependent child is not eligible. Make sure that your dependent child(ren) is eligible and it is your responsibility to cancel your Dependent Term Life coverage when you no longer have any eligible children; otherwise, you will be paying for a benefit that you will not be able to use.

Delayed effective date

Actively at work requirement

If you are not actively at work on the day coverage would start, your Basic Term Life, Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life, excluding newborns, coverage will begin when you return to being actively at work. "Actively at work" means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to travel or allows you to work. Actively at work also includes any normally scheduled days off work, an observed holiday, or PTO.

Nonconfinement clause

For Spouse/Partner Optional Term Life and Dependent Term Life, coverage will start, provided that the person to be covered is not confined at home under a physician's care, receiving or applying to receive disability benefits from any source, or hospitalized because of illness or disease on the date coverage would otherwise start. If so, coverage will be delayed until he or she is released from such hospitalization or confinement (known as the "nonconfinement clause"). It is your responsibility to notify Wells Fargo if your spouse/partner or dependent child, excluding newborns, is confined on their effective date. The nonconfinement clause does not apply to a newborn child.

Statement of Health

Statement of Health form

A Statement of Health form is a document containing a series of questions about the applicant's overall health and is used by MetLife to determine if the applicant meets MetLife's insurability guidelines, based on their underwriting rules. You are required to complete a Statement of Health form for approval by MetLife for:

- Coverage amounts exceeding the guarantee issue amount during initial enrollment for "Optional Term Life" and "Spouse/Partner Optional Term Life."
- Late enrollment requests of any amount for Optional Term Life and Spouse/Partner Optional Term Life.
- A request to cover a new spouse who was previously your domestic partner or a request to increase coverage on that individual. Your previously existing domestic partner who becomes your spouse is not a newly eligible dependent. Therefore, a request to cover or increase coverage on that person requires a completed Statement of Health for approval by MetLife.

Statement of Health process

Enroll directly through Workday when you first become eligible to enroll in the Life Insurance Plan, or during Annual Benefits Enrollment. Enroll any other time in Workday to request late enrollment, or an increase in coverage after your initial enrollment for the following:

- "Optional Term Life" coverage
- "Spouse/Partner Optional Term Life" coverage

After you enroll through Workday, if your or your spouse's or domestic partner's optional term life coverage enrollment requires a Statement of Health, Wells Fargo will immediately notify MetLife of your request for coverage and send you a Workday Inbox message with the Statement of Health link. Any amounts requiring a Statement of Health will be pended and will not display as Calculated Coverage on your Workday Benefits page until after your coverage is approved by MetLife. You will have 60 days to complete and submit the Statement of Health Form. If the form is not completed and submitted within 60 days, the request will be closed and you will have to start the enrollment process over in Workday if you still want the requested coverage amount.

After you have completed and submitted the Statement of Health form, MetLife will determine whether to approve the request for enrollment application based on its underwriting guidelines. If approved, Wells Fargo will update your coverage amount and you can confirm your coverage at any time by viewing your Benefits Statement, which will display updated coverage after the effective date. Coverage will become effective on the first day of the month following the date MetLife approves the application, subject to the following:

- For Optional Term Life coverage, if you are not actively at work, you will have a delayed effective date (see the "Delayed effective date" section on page 7-9).
- For Spouse/Partner Optional Term Life coverage, the effective date of coverage will be delayed if you're not actively at work and will be subject to the nonconfinement clause (see the "Delayed effective date" section on page 7-9).

The associated premium deductions or increase in premium deductions will be reflected in your paycheck that includes the pay period covering the effective date of your approved coverage amount.

Changing coverage

Employment classification changes

If your employment classification changes from intern or flexible to regular or fixed term, you become eligible to enroll in the Life Insurance benefit options and, you must follow "Initial enrollment" as described starting on page 7-8, to enroll in coverage.

Qualified Events

You may make the following changes without providing a Statement of Health form if you are actively at work and submit your election change in Workday within 60 days of your Qualified Event or within 60 days from the date you return from leave if you are on a leave of absence when the Qualified Event occurs, with the exception of newborns, as described in the row titled "Qualified Events" on page 7-7:

- Enroll in or increase your Optional Term Life coverage by one times your covered pay, referred to as "salary" in the Benefits section of Workday,.
- Enroll in Spouse/Partner Optional Term Life coverage at a coverage target of $25,000 (or for birth, adoption, or placement for adoption, increase existing Spouse/Partner Optional Term Life coverage by $25,000).
- Enroll in Dependent Term Life coverage at a coverage target of $20,000 per child.

If you elect to enroll in or increase your Optional Term Life or Spouse/Partner Optional Term Life by more than the amounts listed above, you are required to complete the Statement of Health process. See the "Statement of Health" section on page 7-9 for more information.

Note: If you have a domestic partnership, whether or not your domestic partner is enrolled in any of your Wells Fargo benefits, and then subsequently marry your domestic partner, you cannot enroll in or increase coverage without providing a Statement of Health form for approval by MetLife because your previously existing domestic partner who becomes your spouse is not a newly eligible dependent.

Optional Term Life

For Optional Term Life coverage, the effective date of the change will be the first of the month following the date of the Qualified Event or the first of the month following the date you submitted your election change in Workday, whichever is later, provided that you are actively at work (see the "Delayed effective date" section on page 7-9 for more information). You cannot request to increase your employee Optional Term Life coverage if you are not actively at work. However, you may request a change by submitting your election change in Workday within 60 days of the date you return to being actively at work. After you are actively at work and submit your election change in Workday, your change in coverage will be effective the first of the month following your election change in Workday.

Spouse/Partner Optional Term Life

For Spouse/Partner Optional Term Life coverage, the effective date of the change will be the first of the month following the date of the event or the date you submit your election change in Workday, whichever is later, subject to the actively at work requirement and the nonconfinement clause (see the "Delayed effective date" section on page 7-9). You cannot request to increase your Spouse/Partner Optional Term Life coverage if you are not actively at work. However, you may request a change by submitting your election change in Workday within 60 days of the date you return to being actively at work. After you are actively at work and submit your election change in Workday, your change in coverage will be effective the first of the month following your election change in Workday, subject to the nonconfinement clause.

If you marry or become a domestic partner while you are covered, your new spouse or domestic partner will be covered at $25,000 without enrollment for the first 60 days following the date they become eligible. For coverage to continue after that 60-day period, you must enroll your spouse or domestic partner in Spouse/Partner Optional Term Life coverage in Workday.

If your spouse or domestic partner becomes ineligible for coverage, see the "Decreasing or canceling coverage" section on page 7-11.

Dependent Term Life

Electing coverage for your first eligible child

If you have your first eligible child, as defined in "Chapter 1: Eligibility, Enrollment, and More," while you are insured, that child will be covered at the $20,000 level without enrollment, for the first 60 days following qualification as your dependent child. For coverage to continue after that 60-day period, you must enroll the child in Dependent Term Life Insurance coverage. For Dependent Term Life coverage, the effective date of the change will be the first of the month following the date of the Qualified Event or the date you call Employee Care or submit the election in Workday, whichever is later, subject to the actively at work requirement and the nonconfinement clause, excluding newborns (see the "Delayed effective date" section on page 7-9). You cannot request to enroll in Dependent Term Life coverage if you are not actively at work, with the exception of newborns. However, you may request a change by submitting the election in Workday within 60 days of the date you return to being actively at work. After you are actively at work and submit your election in Workday, your change in coverage will be effective the first of the month following your election change in Workday, subject to the nonconfinement clause, excluding newborns.

Electing coverage for your 2nd and subsequent eligible children

Once enrolled in Dependent Term Life coverage, any subsequent eligible dependent children will automatically be covered on the date they meet the eligibility requirements, subject to the actively at work requirement and the nonconfinement clause, with the exception of newborns (see the "Delayed effective date" section on page 7-9).

When your children no longer meet eligibility requirements

If your dependent becomes ineligible for coverage, see the "Decreasing or canceling coverage" section on page 7-11.

Late enrollment

If you do not enroll in Optional Term Life coverage, Spouse/Partner Optional Term Life coverage, or Dependent Term Life coverage during your initial designated enrollment period or because of a Qualified Event, you may enroll at any time in Workday, provided you are actively at work (if on a leave of absence, elections for Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life, excluding newborns, can be made within 60 days from the date that you return from leave). However, late enrollment procedures require you to complete the Statement of Health process when enrolling late for Optional Term Life or Spouse/Partner Optional Term Life coverage, regardless of coverage selected. For more information, see the "Statement of Health" section on page 7-9.

MetLife will determine whether to approve the late enrollment application based on its underwriting guidelines.

Note: If your late enrollment request is for Dependent Term Life coverage, a Statement of Health is not required.

Decreasing or canceling coverage

You may decrease or cancel your Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage in Workday at any time.

Your obligation to drop ineligible dependents

It is your responsibility to manage your elections in Workday when your dependent no longer meets the eligibility requirements for coverage.

You must review and update your benefit elections in Workday when one of the following occurs:

- Your spouse or domestic partner is no longer eligible for Spouse/Partner Optional Term Life coverage (such as divorce, legal separation, or termination of domestic partnership) and you need to drop this coverage
- You no longer have any children eligible for the Dependent Term Life coverage (such as your child turns age 26, loss of foster parent or legal guardianship appointment, or any other event that results in a loss of eligibility) and you need to drop this coverage

The coverage will be changed effective the first of the month following your election change in Workday. Coverage cannot be decreased or canceled retroactively.

Increasing coverage

You may request an increase to your Optional Term Life or Spouse/Partner Optional Term Life coverage at any time in Workday, provided you are actively at work. If you are on a leave of absence, you must wait until you return from leave and must do so within 60 days of the date that you return from leave. However, a completed Statement of Health form is required for approval by MetLife unless you are increasing coverage as permitted due to a Qualified Event. For more information, see the "Qualified Events" section on page 7-10. MetLife will determine if the coverage increase is approved. If approved, the increased coverage will be effective the first of the month following the approval, subject to the actively at work requirement and the nonconfinement clause, as applicable (see the "Delayed effective date" section on page 7-9 for more information).

Any increase in coverage due to an increase in covered pay, referred to as "salary" in the Benefits section of Workday, or an increase in coverage target will be subject to the actively at work provision (see the "Delayed effective date" section on page 7-9 for more information).

Cost

Wells Fargo pays the entire cost for Basic Term Life coverage. You do not pay for any part of the coverage.

You pay premiums for Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage through after-tax payroll deductions each pay period. Wells Fargo does not contribute to the premium. If your pay is not sufficient to cover your costs for your benefit elections, you are still responsible for your contribution or premiums for coverage. Pay adjustments may be allowed to account for retroactive contributions or premiums from future pay. In some cases, you may be set up on a direct billing process to pay your required contributions and premiums on an after-tax basis.

The premium rate for Optional Term Life is calculated based on your coverage amount, which is calculated based on the coverage chosen and your age and tobacco-user and/or nicotine-user status, as applicable. If your covered pay changes or if you move to a new age group, your premium rates may change. Please refer to the "Covered pay" section starting on page 7-14 for a definition of covered pay. **Note:** Covered pay is referred to as "salary" in the Benefits section of Workday.

The premium rate for Spouse/Partner Optional Term Life is calculated based on the coverage chosen and your spouse/partner's age and tobacco-user and/or nicotine-user status, as applicable.

Premium rates for coverage for individuals who have not used any tobacco and/or nicotine products during the last 12 months are lower than the premium rates for tobacco and/or nicotine users. Tobacco and nicotine products include but are not limited to cigarettes, electronic cigarettes, cigars, pipes, chewing tobacco, nicotine gum, and nicotine patches.

If your or your spouse's or domestic partner's tobacco-free and/or nicotine-user status changes after you enroll, you may change your or your spouse's or domestic partner's tobacco-user and/or nicotine-user status at any time in Workday; however, changing status from tobacco-user and/or nicotine-user to nonuser status requires that the insured be tobacco-free and nicotine-free for at least 12 months. The change will be effective the first of the month following the date you make the change in Workday. Tobacco-user and/or nicotine-user status cannot be changed retroactively.

For example, if you enroll as a tobacco and/or nicotine nonuser but later begin to use tobacco or nicotine products, you must change your status to tobacco and/or nicotine user. Conversely, if you enroll as a tobacco and/or nicotine user and go 12 months without using any tobacco and/or nicotine products, you may change to tobacco-nonuser and/or nicotine-nonuser status. In either case, the new premium will be effective the first of the month following the date you make the change in Workday.

Beneficiaries

If you die while you have Basic Term Life or Optional Term Life coverage, benefits will be paid to the person, persons, trust, or institution you named as your beneficiary in Workday. If a minor child is named as the beneficiary, the proceeds will go into a locked interest-bearing account, known as a Minor on Deposit Account, until the child turns 18, when MetLife will contact the beneficiary and provide information on accessing the funds. If a guardian of the child's estate or conservator of the child's estate has been appointed by the court, the benefits can be paid to the child's estate. You will be asked to name a beneficiary upon enrolling. Please note that the Life Insurance Plan does not permit irrevocable beneficiary designations, other than a Trust or an irrevocable Trust. Please also see the "Transfer of ownership" section on page 7-13.

For Spouse/Partner Optional Term Life and Dependent Term Life coverage, your spouse and your dependent do not get to designate a beneficiary; you (the regular or fixed term employee) are automatically the designated beneficiary. Benefits are automatically paid to you or, if you're deceased, to your estate.

Multiple beneficiaries

Two or more beneficiaries may be specified for Basic Term Life and Optional Term Life coverage. In such a case, the benefit will be shared equally among them unless otherwise specified. If one of the beneficiaries dies before you, the surviving beneficiary (or beneficiaries) receives the death benefit.

Primary and contingent (secondary) beneficiaries

Primary and contingent (secondary) beneficiaries may be designated for Basic Term Life and Optional Term Life coverage. A primary beneficiary receives a death benefit after you die.

If the primary beneficiary dies after you but before receiving payment, the death benefit goes to the estate of the primary beneficiary. A contingent (secondary) beneficiary receives the whole death benefit amount if the primary beneficiary dies before you or at the same time as you.

Changing beneficiaries

You may change the beneficiaries under Basic Term Life and Optional Term Life coverage at any time by going to Workday or accessing the Group Life and Disability Plans Beneficiary Designation Form on FormsOnline (this information cannot be taken over the phone). The change will be effective on the date you update your beneficiary designation.

Payout if no surviving or designated beneficiaries

For Basic Term Life and Optional Term Life coverage, if a beneficiary is not designated, the beneficiary dies before you or at the same time as you, and no contingent (secondary) beneficiary is named, or the contingent (secondary) beneficiary has also died before you or at the same time as you, the death benefit may be paid to your survivors in the following order:

1. Your surviving spouse or domestic partner[1]
2. Equally among your surviving biological and adopted children[2]
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

If you are not the biological or adoptive parent of your spouse's or domestic partner's child but would like that child to receive benefits in the event of your death, you must properly designate the child as your beneficiary.

1. See the "Definitions relating to marital status" section on page 7-12 for more information.
2. Except that if any of the participant's children predecease him or her but leave descendants surviving, such descendants shall take by right of representation the share their parent would have taken, if living.

Definitions relating to marital status

For payment of a benefit if there are no surviving or designated beneficiaries, the following terms have the meanings assigned to them below:

- "Spouse" means the person to whom you are legally married on your date of death under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, or the person who was your current common-law spouse on your date of death in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages.
- "Domestic partner" means a person of the same or opposite gender who is not your spouse as defined above, that meets at least one of the following criteria on your date of death:

– You and the person are joined in a civil union (or other similar formal relationship) on your date of death that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the union was created but is not denominated or recognized as a marriage under the laws of that state or country.

– You and the person share a domestic partnership (or other similar formal relationship) on your date of death that is registered by a city, county, state, or country but is not denominated or recognized as a marriage under the laws of that city, county, state, or country.

– You and the person both meet all of the following requirements:

  i. You shared a single, intimate, committed relationship of mutual caring as of your date of death and intended to remain in the relationship indefinitely.

  ii. You resided together in the same residence and lived in a spouse-like relationship as of your date of death.

  iii. You are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which you reside on your date of death.

  iv. Neither of you was married to another person under either federal, state, or common law, and neither is a member of another domestic partnership as of your date of death.

  v. You were both mentally competent to consent or contract.

  vi. You were both at least 18 years old.

  vii. You were financially interdependent, jointly responsible for each other's basic living expenses, and if asked, your partner is able to provide documentation for three of the following being in effect as of your date of death:

    A. Joint ownership of real property or a common leasehold interest in real property

    B. Common ownership of an automobile

    C. Joint bank or credit accounts

    D. A will that designates the other as primary beneficiary

    E. A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other

    F. Designation of one partner as holding power of attorney for health care decisions for the other

Transfer of ownership

You may transfer your ownership, also referred to as assigning your rights, under the Life Insurance Plan to another individual, Trust, or a Viatical Settlement Provider. If you transfer your ownership to another individual or a Trust, you are transferring your ownership for both Basic Term Life and Optional Term Life coverage. However, for viatical assignments you indicate whether you are applying the assignment to Basic Life coverage, Optional Term Life coverage, or both.

A transfer of ownership means that:

- You automatically waive any rights to change your beneficiary.
- You become ineligible for the Accelerated Benefit.
- If you terminate employment, you automatically waive your right to convert coverage to an individual policy.

You should consult legal and tax advisors before you transfer ownership. MetLife is not responsible for the validity of any assignment or transfer of ownership.

Transfer of ownership forms (also referred to as Absolute Assignment forms) can be found on Forms Online by searching for Absolute Assignment or you can contact Employee Care for additional information on how to transfer your ownership or to request a transfer of ownership form. You and the assignee (new owner) must complete and sign the applicable Transfer of Ownership form and return it as indicated on the form.

If you transfer your ownership, premiums for coverage still apply and are deducted from your paycheck and you are responsible for notifying the new owner of any changes to the Life Insurance Plan, your coverage, and employment status that result in the cancellation of benefits.

Plan benefits

The death benefit under Basic Term Life coverage is one times your covered pay, referred to as "salary" in the Benefits section of Workday, with a minimum plan benefit of $10,000 and a maximum plan benefit of $50,000. For Optional Term Life coverage, the death benefit is based on the multiple (one to ten) you have enrolled in times your covered pay with a minimum plan benefit of $10,000 and a maximum plan benefit of $3,000,000. Your death benefit will be calculated using the covered pay in effect at the time of your death except for terminated employees who are receiving Wells Fargo severance pay, in which case the death benefit will be calculated using the covered pay in effect on your termination date. The death benefit will be adjusted for any accelerated benefit that has been paid out.

For Spouse/Partner Optional Term Life coverage, the death benefit is based on the coverage amount that you have elected as reflected in the Wells Fargo benefit enrollment records, and as approved by MetLife. The death benefit will be adjusted for any accelerated benefit that has been paid out.

For Dependent Term Life coverage, the death benefit for the eligible dependent child is $20,000.

Covered pay

Your covered pay, referred to as "salary" in the Benefits section of Workday, is determined by the job classification code (job class code or job profile) for your position in Workday. To view your covered pay for Basic Term Life and Optional Term Life coverage, view the Life Covered Pay on the View Benefits Annual Rate screen in Workday by selecting View Profile, then Actions, then Benefits, and then View Benefits Annual Rate.

Job class code 2

Most positions within Wells Fargo are job class code 2. For job class code 2 positions, covered pay is defined as your current annual base salary plus eligible incentive compensation paid in the prior calendar year. The life insurance benefit is based on your covered pay on the day before your death. (In a leave of absence situation, your covered pay is frozen on the day before the day your leave begins.)

Annual base salary

- Your annual or hourly* rate of pay indicated in Workday, with hourly pay annualized for the purpose of determining your covered pay.
- Does not include some forms of compensation such as overtime pay, shift differentials, incentives, bonuses (including but not limited to hiring, incentive, and retention bonuses), commissions, noncash awards, and perquisites such as parking or auto allowance or commute subsidies, if applicable.

* Your standard hours are the hours that you're expected to work each week, as maintained in Workday, and are not the same as scheduled hours. Overtime pay and shift differentials are excluded.

Eligible incentive compensation

Includes commissions, bonuses, and other earnings indicated in Workday as eligible incentive compensation.

Job class codes 1 and 5

Mortgage Consultant Participant pay category positions are generally job class 1.

Variable Incentive Compensation (VIC) pay category positions are generally job class code 5. VIC applies to jobs with a pay structure designed to deliver 40% or more of expected total cash through incentives that are paid primarily on a monthly or quarterly basis. Assignment of jobs to VIC (job class code 5 on HCMS) requires approval of Wells Fargo Rewards and Performance Management.

For both job class codes 1 and 5, covered pay is defined as your benefits base. Benefits base is calculated quarterly, and earnings are annualized based on base salary and incentives, incentive bonuses, and commissions paid in the last 12 months, or on a combination of these factors. Generally, quarterly calculations are completed sometime in the first several days of each quarter. The amount of covered pay is updated on the day of the calculation. (In a leave of absence situation, your benefits base is frozen on the day before the day your leave begins.) These earnings are then divided by the number of months with earnings greater than $0, with a minimum benefits base of $20,000. Benefits base does not include some forms of compensation such as overtime pay, shift differentials, hiring and retention bonuses, noncash awards, and perquisites (such as parking or auto allowance or commute subsidies).

Covered pay under the Life Insurance Plan may be calculated differently for certain job class code 1 and 5 positions as explained below.

- **For Financial Consultants:** If you are a designated VIC Financial Consultant in your first 12 months of employment and have an annualized benefits base that has never exceeded the following first-year minimum covered pay amounts, your first-year minimum covered pay base amount is $50,000 for both Basic Term Life and Optional Term Life coverage.
- **For Financial Advisors and Financial Advisor Managers:** If you are a designated Financial Advisor or Financial Advisor Manager in your first 12 months of employment and have an annualized benefits base that has never exceeded the following first-year minimum covered pay amounts, your first-year minimum covered pay base amount is $50,000 for Basic Term Life coverage and $125,000 for Optional Term Life coverage.

The first-year minimum covered pay will remain in place until the earlier of: (1) 12 months from your job start date or (2) until your quarterly benefits base calculation exceeds your first-year minimum covered pay amount. Once your benefits base exceeds your first-year minimum covered pay amount, then going forward, covered pay will be determined under the standard benefits base practice, as stated in the paragraph above, even if your benefits base later falls below the first-year minimum covered pay amount.

It's your responsibility to verify the impact of any changes to your life insurance coverage. You can view the impact by accessing your Benefits Statement after the first payroll period of each quarter; in Workday, select "view profile," then "actions," then "benefits," and then "Benefits Statement." If you want to change your life insurance coverage as a result, see the "Changing coverage" section starting on page 7-10

Seat belt benefit for Basic Term Life

The death benefit will be increased by an additional 20% of the basic life insurance amount, not to exceed $10,000, but no less than $1,000, if a loss of life occurs due to a covered accident while properly using a seat belt in a passenger vehicle. Note that the driver must have been a licensed driver and not intoxicated, impaired, or under the influence of alcohol or drugs at the time of the accident, and the official accident report must indicate that a seat belt was properly used. If the official accident report is unclear about the proper use of a seat belt, the seat belt benefit is limited to $1,000. No seat belt benefit is payable if the official accident report is either not provided or if the report indicates that no seat belt was worn.

Accelerated Benefit

Basic Term Life, Optional Term Life, and Spouse/Partner Optional Term Life coverage provides an Accelerated Benefit, which is an advance payment before death of a part or the total amount of the plan benefit. Contact Wells Fargo Survivor Support directly at 1-877-374-7987 to initiate a claim for an Accelerated Benefit. To qualify for an Accelerated Benefit, the insured must:

- Be insured for at least $10,000.
- Have not assigned his or her rights under the Life Insurance Plan.
- Be terminally ill (expected to die within 12 months).
- Send proof of terminal illness to MetLife that the insured's life expectancy, because of sickness or injury, is 12 months or less. This must include certification by a physician. MetLife retains the right to have the insured medically examined at MetLife's expense to verify the medical condition.

An Accelerated Benefit is not available if the insured is:

- Required by law to use this as an option to meet the claims of creditors, whether in bankruptcy or otherwise
- Required by a government agency to use this as an option to apply for, obtain, or keep a government benefit or entitlement

The Accelerated Benefit option will end on the earliest of:

- The date life insurance coverage terminates
- The date you transfer ownership of (assign) your life insurance benefits
- The date you have accelerated all life insurance benefits

If the insured qualifies for an Accelerated Benefit, he or she can request either a full or partial payment as shown in the table below.

	Full Accelerated Benefit	**Partial Accelerated Benefit**
Benefit amount	100% of the life insurance coverage amount in effect at the time of the request, up to a maximum Accelerated Benefit of: • $50,000 for Basic Term Life • $1,000,000 for Optional Term Life • $250,000 for Spouse/Partner Optional Term Life	Any partial amount of the life insurance coverage amount in effect at the time of the request, up to a maximum Accelerated Benefit of: • $50,000 for Basic Term Life • $1,000,000 for Optional Term Life • $250,000 for Spouse/Partner Optional Term Life
Policy in force	Coverage ceases.	Coverage remains in force less the amount accelerated. Premium is waived on any coverage that remains in force.

Benefits received under this Accelerated Benefit provision may be taxable. The insured should seek assistance from a tax advisor before requesting an accelerated payment of death benefits. The Accelerated Benefit can only be paid once for each eligible life insurance participant.

Note: Any death benefit payable will be adjusted for the Accelerated Benefit that has been paid out.

Life Insurance Plan claims and appeals

Filing a claim

To file a claim under the applicable coverage option of the Life Insurance Plan, follow these steps:

1. The beneficiary should contact Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to notify Wells Fargo of the death and begin the claims process as soon as possible after the death. (Employee Care will inform Survivor Operations, who will send the beneficiary an initial communication regarding benefit actions required.)
2. The beneficiary should be prepared to send a copy of the certified death certificate to Survivor Operations after receiving the initial communication mentioned above (Survivor Operations will notify MetLife of the death after step 1 has been completed and a copy of the certified death certificate has been received).

Claim determination

After the beneficiary has followed the steps for filing a claim, MetLife processes the claim. MetLife may require additional documents to make a determination of payment. MetLife will make these requests directly to the beneficiary.

If the claim is approved, the benefit will be paid within 10 days of receipt of all required documentation. The normal form of payment is a lump sum, but other alternative payments are available. Contact MetLife for information about other payment options.

Note: Except for fraud and nonpayment of premium, your, your spouse's or domestic partner's, or your dependent children's life insurance coverage under this plan that has been in force for two years from the effective date of coverage cannot be contested by MetLife. However, for any increase in life insurance coverage approved under this plan after MetLife completes its review of the submitted Statement of Health form for you, your spouse or domestic partner, or your dependent children, MetLife may contest the amount of increased life insurance coverage if a loss occurs within two years of the effective date of the increase in coverage amount, and MetLife may not pay the claim subject to the increased coverage amount.

You or your beneficiaries will receive written notice from MetLife to inform you of the decision to approve or deny your claim (regardless of whether the claim is complete with all necessary information). This notification will be provided to you or your beneficiaries within a reasonable period, not to exceed 90 days from the date MetLife received the claim, unless MetLife determines that special circumstances justify an extension of an additional 90 days, in which case MetLife will notify you or your beneficiaries of the need for an extension before the end of the initial 90-day period.

If part or all of the claim is denied, the notice will include:

- The reason for denial
- Reference to the pertinent Life Insurance Plan provision on which the denial is based
- A description of any additional materials or information necessary to appeal the claim (and why it's necessary)
- Instructions for appealing the denied claim
- A statement of your right to appeal the decision and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of the claim on appeal

If you have questions about the claim determination, you can call MetLife at 1-866-549-2320. You also have the right to file an appeal without first calling the insurer.

Filing an appeal

When any claim is denied in whole or in part, you, your beneficiary, or your executor has the right to submit a request for review to MetLife. Requests for review must be in writing and submitted within 60 days of receiving MetLife's decision. Submissions for a request for review need to be sent to:

MetLife
Group Life Claims
PO Box 6100
Scranton, PA 18505-6100

If you or your beneficiaries, your beneficiaries, or your executor request a review, include the following:

- The reason you or your beneficiaries, your beneficiaries, or your executor believe the claim was improperly denied
- Any written comments, documents, records, or other information deemed appropriate

Authorizing a representative

You have the right to have someone file an appeal review request on your behalf or represent you in the appeal process. To authorize someone to represent you, you must submit a written authorization to MetLife that includes the following:

- The name and address of the person authorized to represent you
- The purpose for which the individual is representing you
- The time period for which the individual will be your authorized representative
- The types of documents, records, or other items that may be requested of or released to the authorized individual

Note: Neither the insurer, the plan administrator, Wells Fargo, nor the plan are responsible for your authorized representative's disclosure of information provided to the authorized representative or that individual's failure to protect such information.

If you wish for an authorized representative to request and receive a copy of the SPD or plan document on your behalf, an authorization for representation statement as described above must be submitted to the plan administrator with the SPD or plan document request.

Appeal review and determination

MetLife's written decision is sent directly to you or your beneficiary within 60 days after MetLife's receipt of the review request. If an extension is required, MetLife will notify you or your beneficiary of the need for an extension before the end of the initial 60-day period. If MetLife denies the claim on appeal, the final written decision will include:

- The reason or reasons for the denial
- References specific to the Life Insurance Plan provisions on which the denial is based
- Any voluntary appeal procedures offered by the Life Insurance Plan
- A statement that you are entitled to receive — upon request and free of charge — all documents, records, and other information relevant to your claim for the Life Insurance Plan benefits
- A statement of your right to bring a civil action under Section 502(a) of ERISA

MetLife (the insurer) shall serve as the named fiduciary under the Life Insurance Plan and shall have sole and complete discretionary authority to determine conclusively for all parties and, in accordance with the terms of the documents or instruments governing the Life Insurance Plan, any and all questions arising from:

- Administration of Life Insurance claims and interpretation of all provisions of the Life Insurance Plan
- Determination of all facts that are relevant to a claim for benefits
- Determination of the documents, records, and other information that are relevant to a claim for benefits
- Determination of benefits to be provided to any participant or beneficiary
- Construction of all terms of the policyDecisions by MetLife shall be conclusive and binding on all parties.

Neither the plan administrator nor Wells Fargo provides a review of claims for life insurance benefits or pays any life insurance benefits.

Legal action

No legal action can be taken until the Wells Fargo & Company Life Insurance Plan's claims and appeals procedures have been exhausted (refer to the "Claims and appeals" section starting on page 7-16 for more information).

Benefits when you're not working

Coverage while on a leave of absence

When you're on an approved leave of absence, you may be able to continue life insurance coverage even if you are not actively working for Wells Fargo. For Basic Term Life, coverage may continue during your approved leave, generally up to a maximum of 24 months.

For Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage, you must continue paying the premiums during your leave to keep the coverage. If coverage was canceled due to nonpayment of premiums or you elected to cancel the coverage, you can apply for coverage at any time but will be required to submit a completed Statement of Health form for approval by MetLife. For additional information on continuing your benefit while on an approved leave of absence, see "Appendix D: Leaves of Absence and Your Benefits."

Coverage for terminated employees who are receiving Wells Fargo severance pay

For information, refer to "Coverage for terminated employees who are receiving Wells Fargo severance pay" in "Chapter 1: Enrollment, Eligibility, and More."

Coverage termination date

If you elect to continue your life insurance coverage with MetLife, through one of the options detailed below, your coverage will be retroactively effective to the date after your coverage end date, causing no lapse in coverage, assuming you provide all required information by the deadline included in the MetLife continuation of coverage packet. The applicable Life Insurance Plan coverage option ends on the last day of the month in which certain events occur, as shown below. However, you may have the option to continue coverage directly with MetLife as described in the "After coverage ends: Your options" section, starting below the following table.

Event	Basic Term Life	Optional Term Life	Spouse/Partner Optional Term Life	Dependent Term Life
Your last day of employment or the last day of your severance eligibility period under the Wells Fargo & Company Severance Plan, whichever occurs later[1].	Coverage ends on the last day of the month for all life insurance coverage options.			
You no longer meet the eligibility requirements.	Coverage ends on the last day of the month for all life insurance coverage options.			
Your spouse or dependent no longer meets the eligibility requirements.	NA	NA	Coverage ends on the last day of the month.	Coverage ends on the last day of the month.
You do not pay the required premium.	NA	Coverage ends on the last day of the month for which full payment was received.		
You voluntarily cancel coverage.	NA	Coverage ends on the last day of the month in which you make an election to cancel or drop coverage. (**Exception:** If you make an election to cancel or drop coverage during Annual Benefits Enrollment, coverage ends December 31 of the year in which the Annual Benefits Enrollment election was made.)		
The Life Insurance Plan or an option under the plan is discontinued or terminated[2]	Coverage under the Life Insurance Plan ends if the plan is discontinued or terminated regardless of any of the events noted above. Coverage under a specific option of the Life Insurance Plan ends if that option is discontinued or terminated regardless of any of the events noted above.[2]			

1. If you are rehired by Wells Fargo as a regular or fixed term employee and your first day of reemployment occurs during your severance eligibility period, any benefits that are in effect on the day before your rehire will continue as a rehired employee. For more information, see the "Rehired employees" section in "Chapter 1: Eligibility, Enrollment, and More."
2. For information on Wells Fargo's ability to amend, modify, or terminate the Life Insurance Plan, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

After coverage ends: Your options

If you elect to continue your life insurance coverage with MetLife, through one of the options detailed below, your continued coverage will be retroactively effective to the date after your coverage end date described in the table above, causing no lapse in coverage, assuming you provide all required information by the deadline included in the MetLife continuation of coverage packet and make the timely payment for your continued coverage. Learn more about portability and conversion, including portability rates, for life insurance by accessing metlife.com/wf.

Portability (or porting)

Portability (porting) is a provision that gives you the option to continue your current Term Life coverage amounts under a MetLife group Term Life policy after your coverage through the Life Insurance Plan ends. Refer to the "When coverage ends" section on page 7-18 for more information on when coverage ends. Term Life insurance provides coverage to a specified age (as specified in the "porting rules per covered options" bullets below), and has no cash value. Rates will typically increase as the insured ages but is typically less expensive than converting coverage. Portability is available on Basic Life, Optional Life, Spouse/Partner Optional Term Life, and Dependent Life.

You cannot port your coverage if you:

- Have converted your insurance to an individual policy
- Lose eligibility due to termination of the group policy

Porting rules per covered options are listed below:

- Basic Term Life: You may port all or a portion of your Basic Term Life coverage. Your coverage will reduce 50% at age 70 and will terminate at age 100.
- Optional Term Life: You may port all or a portion of your Optional Term Life coverage, up to a maximum of the lesser of your total life insurance in effect on the date you elect to port or $2,000,000. Your coverage will reduce 50% at age 70 and will terminate at age 100.
- Spouse/Partner Optional Term Life: You can port all or a portion of your Spouse/Partner Optional Term Life coverage up to a maximum of the lesser of your total Spouse/Partner Optional Term Life coverage in effect on the date you elect to port or $250,000. Your Spouse/Partner Optional Term Life coverage will terminate at age 70.
- Dependent Term Life: You can port all or a portion of your Dependent Term Life coverage, up to a maximum of the lesser of your total Dependent Term Life coverage in effect on the date you elect to port or $20,000. Your Dependent Term Life coverage will terminate at age 25. If your child is over age 25 when they lose coverage, they will be offered to port their coverage to a MetLife individual term life policy.

How to apply — portability

Upon termination of group coverage through Wells Fargo, you will receive information directly from MetLife regarding portability of coverage. If you do not receive this information within 30 days of the date your coverage ends, contact MetLife at 1-866-549-2320.

If the portability information from MetLife is dated within 15 days after the date your coverage ends, you will have 31 days from the date your coverage ends to send the completed portability form and first premium payment to MetLife.

If the portability information from MetLife is dated more than 15 days but within 91 days from the date your coverage ends, you will have 45 days from the date of the portability information letter to send the completed portability form.

The premium rate you pay is the group rate set by MetLife and will be included in the information you receive from MetLife. If you fail to pay any premiums by the due date, your ported coverage will end.

Conversion

Conversion is a provision which gives the option to convert current group Term Life coverage amounts to an Individual Whole Life insurance policy if group coverage terminates for any reason other than failure to pay the required premium. Whole Life insurance is a life insurance product that builds cash value and, provided premiums are paid, provides coverage through a specified age (age 120 for MetLife's converted coverage). Rates are based on the coverage amount and issue age of the insured, are typically more expensive than porting coverage, and typically do not increase as you get older. Conversion is available on Basic Life, Optional Life, Spouse/Partner Optional Term Life, and Dependent Life. in the event of your death or if they no longer meet the eligibility requirements.

Refer to the "When coverage ends" section on page 7-18 for more information on when coverage terminates.

How conversion works

- Conversions are to an individual life insurance policy, administered by a third party financial professional.
- The conversion application must be sent to MetLife within 31 days after the termination of coverage. If you die during this 31-day conversion period, benefits will be paid to your beneficiary whether or not the policy had been converted.
- The maximum amount that can be converted is the coverage amount when your coverage under the Life Insurance Plan ends.
- Premiums you pay for the converted policy are based on your current age at the time of conversion and will differ from the rates you paid while employed.
- The insured is not required to undergo a physical examination before converting the coverage.

How to apply — conversion

Upon termination of group coverage through Wells Fargo, you will receive an informational letter directly from MetLife regarding conversion of coverage. MetLife has arranged for a third party financial professional to help explain your options, if you choose, since MetLife cannot provide you with individual guidance. If you have questions about conversion of coverage, would like to arrange a meeting with a third party financial professional, or if you do not receive this informational letter within 30 days of the date your coverage ends, contact MetLife at 1-866-549-2320.

If the conversion information from MetLife is dated within 15 days after the date your coverage ends, you will have 31 days from the date your coverage ends to apply for conversion following the instructions in the letter.

If the conversion information from MetLife is dated more than 15 days but within 91 days from the date your coverage ends, you will have 15 days from the date of the conversion information letter to apply for conversion following the instructions in the letter, but not to exceed 91 days.

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Chapter 8: Business Travel Accident Plan

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Benefits when you're not working **8-11**

When coverage ends **8-11**

Conversion **8-11**

Contacts

Information about Business Travel Accident Plan provisions	HR Services & Support site
Information about Business Travel Accident Plan enrollment	Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.
Questions about Claims status	Metropolitan Life Insurance Company (“MetLife”) 1-866-549-2320

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More" and "Appendix B: Important Notifications and Disclosures" — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Business Travel Accident Plan (the BTA Plan).

The basics

General information

The SPD is a summary of provisions for the Business Travel Accident Plan and its underlying fully insured policy issued by Metropolitan Life Insurance Company ("MetLife") and the corresponding Certificate of Insurance ("certificate"). For further details, contact Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to request a copy of the certificate. Individual certificates are not available. The SPD and Group Policy Number 164933-BTA issued by MetLife, along with any applicable certificates, policy amendments, riders, and endorsements (collectively the "Group Policy"), constitute the official plan document for this BTA Plan. If there are differences between the SPD and the Group Policy, the Group Policy governs your rights to benefits.

The BTA Plan is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Insurer and claims administrator

The BTA Plan is insured by Metropolitan Life Insurance Company ("MetLife"). MetLife is the named fiduciary and has sole and complete discretionary authority to administer claims and interpret benefits under the BTA Plan.

BTA coverage

BTA coverage helps provide financial protection if you are in a "covered accident" (as defined below) and within 365 days of the date of the covered accident any of the following happen. You:

- Die
- Become paralyzed
- Suffer the loss of limb, speech, hearing, or sight
- Are in a coma that commences within 365 days of the date of a covered accident
- Suffer brain damage

A "covered accident," as used throughout this SPD, is defined as a sudden, unforeseeable, external event that results directly, and independently of all other causes, in a covered injury or covered loss and meets all of the following conditions:

- Occurs while you are insured under this BTA Plan.
- Occurs while you are on company-authorized Wells Fargo business travel[1,2] for a business trip lasting less than 180 days.[3]
- Is not contributed to by disease, sickness, or mental or bodily infirmity.
- Is not otherwise excluded under the terms of this SPD or the BTA Plan's policy.

1. When traveling on Wells Fargo business, coverage begins when you leave your home or place of work. Generally, coverage continues until you return home. You are protected in cases of accidents that occur while driving a vehicle (including a rental vehicle), riding as a passenger in someone else's vehicle, or traveling in a nonexperimental commercial or company-owned aircraft, or other modes of transportation for business purposes. However, you are not covered for normal commuting between your home and place of work, nor are you covered if you are participating in any race or speed contest, or if you are driving any vehicle for pay or hire. In addition, you are not covered for any activity which is not reasonably related to or incidental to the purpose of travel for which coverage is provided by this BTA Plan. It will be deemed that your regular place of work has changed and traveling on business has ended if:
   a. You are expected to remain in the new location to which you have traveled on business for more than 180 days
   b. Wells Fargo deems a new location to be your regular place of work
2. You are also covered under the "Felonious assault benefit" and the "Terrorist act business travel coverage" when you are on the premises of Wells Fargo during your regularly scheduled working hours at the time of the incident resulting in the covered accident, in addition to being covered while on authorized Wells Fargo business.
3. This benefit will not extend beyond the length of your business travel as approved by Wells Fargo, even if that approval is for more than 180 days.

BTA Plan at a glance

	Business Travel Accident (BTA)
How do I enroll?	You are automatically enrolled, if you are eligible
MetLife policy number	164933-BTA
Type of ERISA plan	Welfare benefit plan
Who's eligible	Regular and fixed term employees
Who's not eligible	• Intern or flexible employees • Dependents
Beneficiary	The person, persons, trust, or institution you designated (or if none, according to the "Payout if no surviving or designated beneficiary" section starting on page 8-5)
Cost	None — Wells Fargo pays the full cost
Coverage effective date	Date of hire or effective date of your employment classification change from intern or flexible to regular or fixed term, provided that you are actively at work on the day coverage is scheduled to begin
Cancel coverage	You cannot cancel coverage
Conversion	No conversion privilege
Coverage when you're not working (approved leave of absence)	Coverage will not continue when you are not actively at work
BTA Plan death benefits	5 × covered pay, referred to as "salary" in the Benefits section of Workday Maximum plan benefit: $2,000,000, subject to the policy's aggregate maximum accident limitation
BTA Plan dismemberment, paralysis, brain damage, and coma benefits	See the "Dismemberment, paralysis, brain damage, and coma benefits" section on page 8-8 for benefits available under the BTA plan.

Who's eligible

Regular and fixed term Wells Fargo employees, as described in "Chapter 1: Eligibility, Enrollment, and More" in this *Benefits Book*, are eligible to participate in the BTA Plan. Interns and flexible employees are not eligible for coverage. Dependents are not eligible for coverage.

How to enroll

Initial enrollment

If you meet the eligibility requirements, you are automatically enrolled under the BTA Plan on your date of hire, provided that you are actively at work on that date. "Actively at work" means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to travel or allows you to work.

Employment classification changes

You will automatically be enrolled in the BTA Plan on the effective date of your employment classification change from intern or flexible to regular or fixed term, provided that you are actively at work on that date.

Delayed effective date

If you are not actively at work on the day coverage normally would begin, coverage will begin when you return to being actively at work. "Actively at work" means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to travel or allows you to work.

Changing coverage

Changing coverage is not an option under the BTA Plan. Coverage is automatically canceled when you are no longer eligible or not actively at work.

Cost

Wells Fargo pays the entire cost for BTA coverage. You do not pay for any part of the coverage.

Beneficiaries

If you die in a covered accident while covered under the BTA Plan, benefits will be paid to the person or persons, trusts, or institutions you named as your beneficiary in Workday.

When making a beneficiary decision, keep in mind the beneficiary may be a person, trust, charitable institution, or your estate. However, if a minor child is named as the beneficiary, the proceeds will go into a locked interest bearing account until the child turns age 18. If a guardian of the child's estate or conservator of the child's estate has been appointed by the court, the benefits can be paid to the child's estate. If you need to change your beneficiaries during the year, you may do so at any time in Workday.

Multiple beneficiaries

You may name more than one beneficiary for your benefit under the BTA Plan. In that case, the death benefit is shared equally among them — unless you designate otherwise. If one of the beneficiaries dies before you, the surviving beneficiaries receive the death benefit.

Primary and contingent (secondary) beneficiaries

You may name primary and contingent (secondary) beneficiaries for your benefit under the BTA Plan. A primary beneficiary receives a death benefit after you die from a covered accident. If a primary beneficiary dies after you die but before receiving payment, the death benefit goes to the estate of the primary beneficiary. A contingent (secondary) beneficiary receives the death benefit only if the primary beneficiaries die before you die.

Changing beneficiaries

You may change beneficiaries under the BTA Plan at any time in Workday. The change becomes effective on the date you make the change.

Payout if no surviving or designated beneficiary

If you do not choose a beneficiary — or if all of your designated primary and contingent (secondary) beneficiaries die before you — the BTA benefit may be paid after your death to the following categories of individuals (in the order listed below) in which one or more individuals survive you:

1. Your surviving spouse or domestic partner[1]
2. Equally among your surviving biological and adopted children[2]
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

1. See the "Definitions relating to marital status" section starting on this page for more information.

2. Except that if any of the participant's children predecease him or her but leave descendants surviving, such descendants shall take by right of representation the share their parent would have taken, if living.

If you are not the biological or adoptive parent of your spouse's or domestic partner's child, but would like that child to receive benefits in the event of your death, you must designate him or her as your beneficiary.

Definitions relating to marital status

For payment of a benefit if there are no surviving or designated beneficiaries, the following terms have the meanings assigned to them below:

- "Spouse" means the person to whom you are legally married on your date of death under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, or the person who was your current common-law spouse on your date of death in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages.
- "Domestic partner" means a person of the same or opposite gender who is not your spouse as defined above, that meets at least one of the following criteria on your date of death:
  - You and the person are joined in a civil union (or other similar formal relationship) on your date of death that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the union was created but is not denominated or recognized as a marriage under the laws of that state or country.
  - You and the person share a domestic partnership (or other similar formal relationship) on your date of death that is registered by a city, county, state, or country but is not denominated or recognized as a marriage under the laws of that city, county, state, or country.
  - You and the person both meet all of the following requirements:
    i. You and your domestic partner shared a single, intimate, committed relationship of mutual caring prior to your date of death and intended to remain in the relationship indefinitely.
    ii. You resided together in the same residence and lived in a spouse-like relationship prior to your date of death.

iii. You and your domestic partner are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which you reside.

iv. Neither you nor your partner was married to another person under either federal, state, or common law, and neither is a member of another domestic partnership.

v. You and your partner were mentally competent to consent or contract.

vi. You were both at least 18 years old.

vii. You and your partner were financially interdependent, jointly responsible for each other's basic living expenses, and if asked, your partner is able to provide documentation for three of the following:

A. Joint ownership of real property or a common leasehold interest in real property

B. Common ownership of an automobile

C. Joint bank or credit accounts

D. A will that designates the other as primary beneficiary

E. A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other

F. Designation of one partner as holding power of attorney for health care decisions for the other

Assigning rights

You are not permitted to assign any of your rights under the BTA Plan, including without limitation your right to designate beneficiaries.

BTA Plan benefits

When BTA Plan benefits are payable

The BTA Plan is designed to pay a benefit if you are in a "covered accident" (as defined in the "BTA coverage" section on page 8-3) and within 365 days of the covered accident any of the following happen. You:

- Die
- Become paralyzed
- Suffer the loss of limb, speech, hearing, or sight
- Are in a coma that commences within 365 days of the date of a covered accident
- Suffer brain damage

No benefits are paid if the loss is caused or contributed to by illness or any of the causes listed in the "What is not covered" section starting on page 8-9.

Death benefit amount

The death benefit under the BTA Plan is five times your covered pay, referred to as "salary" in the Benefits section of Workday, with a maximum plan benefit amount of $2,000,000. Your death benefit will be calculated using the covered pay in effect at the time of your death. Covered pay is explained below.

Covered pay

Your covered pay, referred to as "salary" in the Benefits section of Workday, is determined by the job classification code (job class code) for your position in Workday. To view the compensation amounts used to determine your covered pay, for Business Travel Accident coverage, refer to the Life Covered Pay on the View Benefits Annual Rate screen in Workday by selecting View Profile, then Actions, then Benefits, and then View Benefits Annual Rate.

Job class code 2

Most positions within Wells Fargo are job class code 2. For job class code 2 positions, covered pay is defined as your current annual base salary plus eligible incentive compensation paid in the prior calendar year. The BTA benefit is based on your covered pay on the day before your covered accident or death.

Annual base salary

- Your annual or hourly* rate of pay indicated in Workday, with hourly pay annualized for the purpose of determining your covered pay.
- It does not include some forms of compensation such as overtime pay, shift differentials, incentives, bonuses (including but not limited to hiring, incentive, and retention bonuses), commissions, noncash awards, and perquisites such as parking or auto allowance or commute subsidies, if applicable.

* Your standard hours are the hours that you're expected to work each week, as maintained in Workday, and are not the same as scheduled hours. Overtime pay and shift differentials are excluded.

Eligible incentive compensation

Includes commissions, bonuses, and other earnings indicated in Workday as eligible incentive compensation.

Job class codes 1 and 5

Mortgage Consultant Participant pay category positions are generally job class code 1.

Variable Incentive Compensation (VIC) pay category positions are generally job class code 5. Variable Incentive Compensation (VIC) applies to jobs with a pay structure designed to deliver 40% or more of target cash through incentives that are paid primarily on a monthly or quarterly basis. Assignment of jobs to VIC (job class code 5 in Workday) requires approval of Wells Fargo Rewards and Performance Management.

For both job class codes 1 and 5, covered pay, referred to as "salary" in the Benefits section of Workday, is defined as your benefits base. Benefits base is calculated each quarter and earnings are annualized based on base salary and incentives, incentive bonuses, and commissions paid in the last 12 months or on a combination of these factors. Generally, quarterly calculations are completed within the first several days after the start of the quarter.

The amount of covered pay is updated on the day of the calculation. (In a leave of absence situation, your benefits base is frozen on the day before the day your leave begins.) These earnings are then divided by the number of months with earnings greater than $0, with a minimum covered pay of $20,000. Benefits base does not include some forms of compensation such as overtime pay, shift differentials, hiring and retention bonuses, noncash awards, and perquisites (such as parking, auto allowance, or commute subsidies).

Felonious assault benefit

If a covered accident, as defined by the plan, is the result of a felonious assault as described below, you are eligible for the BTA Plan's applicable death benefit or dismemberment, paralysis, brain damage, and coma benefits. The BTA Plan will pay a benefit of 25% of the amount of coverage indicated in the "Death benefit amount" section on page 8-6 up to a maximum plan benefit of $100,000, if the insured's covered loss results from a covered accident that occurs due to another person's actions during a felonious assault as follows:

- An actual or attempted robbery or holdup
- An actual or attempted kidnapping
- Any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred

A felonious assault is defined as an assault committed during the commission of a felony or its equivalent as defined by the laws of the jurisdiction in which the act was committed. The act must be committed by someone other than:

- You
- A member of your immediate family (includes spouse, domestic partner, children, parents, siblings, grandparents, and grandchildren)
- A Wells Fargo employee

Hospital stay benefit

The BTA Plan will pay this benefit if any of the following apply:

- Proof is received that you are confined in a hospital as a result of an accidental injury sustained in a covered accident
- This benefit is in effect on the date of the injury
- The confinement occurs within 12 months of the covered accident

The BTA Plan will pay an amount for each full month of hospital confinement equal to the lesser of one of the following:

- 1% of the amount of coverage indicated in the "Death benefit amount" section on page 8-6
- $2,500

The BTA Plan will pay this benefit on a monthly basis beginning on the fifth day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a prorated basis for any partial month of confinement. The BTA Plan will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

Seat belt and airbag benefit

The death benefit will be increased by an additional 25% of the amount of coverage indicated in the "Death benefit amount" section on page 8-6, not to exceed $50,000, but no less than $1,000, if a loss of life occurs due to a covered accident while properly using a seat belt in a passenger vehicle. No seat belt benefit increase is payable if the official accident report is not provided or if the report indicates that no seat belt was worn.

The death benefit will be increased by an additional 5% of the amount of coverage indicated in the "Death benefit amount" section on page 8-6, not to exceed $12,000, but no less than $1,000, if a loss of life occurs due to a covered accident while positioned in a seat protected by a properly functioning and properly deployed airbag in a passenger vehicle.

Wheelchair benefit

This benefit is payable when due to a covered accident, the permanent use of a wheelchair is required to be ambulatory and in order to provide wheelchair accessibility, alterations are done to your primary residence and one vehicle you use; and the alterations to your primary residence are done by a licensed contractor.

The home alteration expenses may include installing ramps, widening doors, and lowering cabinets. They may not include remodeling expenses that have no direct relationship to providing wheelchair accessibility. The BTA Plan will pay up to 25% of the amount of coverage indicated in the "Death benefit amount" section on page 8-6 up to a maximum plan benefit of $50,000.

Accident limitation

If multiple employees traveling together are injured in the same common accident, the policy aggregate maximum plan benefit is $50,000,000.

The benefit will pay no more than the policy aggregate maximum plan benefit for all covered losses for all covered employees as the result of any one covered accident. If this amount does not allow all covered employees to be paid the amounts this policy otherwise provides, the amount paid will be the proportion of the covered employee's loss to the total of all losses, multiplied by the policy aggregate maximum.

Dismemberment, paralysis, brain damage, and coma benefits

If you are in a covered accident (as defined in the "BTA coverage" section on page 8-3) and within 365 days of the covered accident you lose a limb, sight, hearing, or speech; are paralyzed; have brain damage; or if a coma commences within 365 days from the date of the covered accident while you are covered under the BTA Plan, you will receive a benefit according to the following schedule:

	Loss	Amount paid
Dismemberment	Both hands or both feet or sight in both eyes; speech and hearing in both ears; or any two or more such losses in any combination	100% of covered amount*
	One hand, one foot, sight in one eye, speech, or hearing in both ears	50% of covered amount*
	Thumb and index finger of the same hand, all four fingers of same hand, or all toes of same foot	25% of covered amount*
Total paralysis	Both upper and lower limbs (quadriplegia)	100% of covered amount*
	Both upper or both lower limbs (paraplegia)	75% of covered amount*
	An upper and lower limb on one side of the body (hemiplegia)	50% of covered amount*
	One upper or lower limb (uniplegia)	50% of covered amount*
Brain damage	Brain damage resulting from a covered accident	100% of covered amount*
Coma	A coma resulting from a covered accident	1% of covered amount* (1% will be paid monthly, continuing for 11 consecutive months, with the remaining balance paid as a lump sum on the 12th month)

* Covered amount is equal to 5 times covered pay not to exceed $2,000,000.

Covered losses, total paralysis, brain damage, and coma are defined as follows:

- Loss of a hand or foot means complete severance through or above the wrist or ankle joint.
- Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye, or the field of vision must be less than 20 degrees.
- Loss of speech means a loss of speech continuing for six consecutive months, after which a physician must determine the loss to be entire and irrecoverable.
- Loss of hearing means a loss of hearing continuing for six consecutive months, after which a physician must determine the loss to be entire and irrecoverable.
- Loss of a thumb and index finger of the same hand or four fingers of the same hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
- Loss of toes means complete severance through the metatarsal phalangeal joint.
- Paralysis or paralyzed means total loss of use of a limb. A physician must determine the loss of use to be complete and irreversible.
- Severance means the complete and permanent separation and dismemberment of the part from the body.
- Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least five days, and persist for 12 consecutive months after the date of the accidental injury.
- Coma means a profound state of unconsciousness that resulted directly and solely due to a covered accident and from which you are not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a covered injury, unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that covered accident.

Other BTA Plan provisions

The following provisions apply to death, dismemberment, paralysis, brain damage, and coma benefits resulting from a covered accident:

- Benefits are paid for any covered loss that occurs within 365 days following the date of the covered accident.
- Benefits are paid if a coma commences within 365 days of the covered accident.

Exposure and disappearance coverage

Benefits are paid if you suffer a covered loss that results directly from and solely due to a covered accident during the course of a Wells Fargo authorized business trip that causes you unavoidable exposure to the elements and is a direct result of a covered accident independent of other causes.

The BTA Plan will presume that the covered loss sustained by you for such loss is loss of life if:

- An aircraft or other vehicle in which you were traveling on business for which coverage is provided under a covered accident disappears, sinks, or is wrecked
- Your body is not found within one year of:
  - The date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a common carrier
  - The date you are reported missing to the authorities, if traveling in any other aircraft or vehicle

Personal deviation business travel

Benefits are paid if, while making a personal deviation, an accidental bodily injury resulting in a covered loss is sustained and the covered loss:

- Takes place while on a business trip requested, authorized, or consented to by Wells Fargo, for the purpose of furthering the business of Wells Fargo and at the expense of Wells Fargo
- Takes place more than 100 miles from your home or regular place of work
- Does not take place during a leave of absence

Personal deviation cannot be longer than 14 days and is defined as any travel or activity:

- Not reasonably related to the business of Wells Fargo
- Not incidental to the business trip, and not at the expense of Wells Fargo

War risk business travel coverage

War risk coverage provides benefits for covered accidents caused by war or acts of war worldwide when in a country other than the United States and war occurs. The following countries are also excluded from these benefits: Afghanistan, Algeria, Burkina Faso, Burundi, Central African Republic, Cote d' Ivoire, Democratic Republic of the Congo, Egypt, Eritrea, Ethiopia, Guinea, Iran, Iraq, Libya, Madagascar, Mali, Nigeria, North Korea, Pakistan, Somalia, South Sudan, Sudan, Syria, Tajikistan, Yemen, and Zimbabwe.

Terrorist act business travel coverage

Benefits will be paid for a covered accident due to a terrorist act sustained while traveling on business except to, from, and within: Afghanistan, Algeria, Burkina Faso, Burundi, Central African Republic, Cote d' Ivoire, Democratic Republic of the Congo, Egypt, Eritrea, Ethiopia, Guinea, Iran, Iraq, Libya, Madagascar, Mali, Nigeria, North Korea, Pakistan, Somalia, South Sudan, Sudan, Syria, Tajikistan, Yemen, and Zimbabwe.

You are covered from an accident caused by an "act of terrorism" if sustained on the premises of Wells Fargo.

Terrorist act means a politically or socially motivated act of violence carried out by an individual or group of persons who may or may not be operating on behalf of a sovereign state with the intent to change political or social policy. A terrorist act does not include any act of violence carried out by a branch of the armed forces.

What is not covered

The BTA Plan will not pay benefits for any loss caused or contributed to by:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity
- Suicide or attempted suicide
- Intentionally self-inflicted injury
- Infection, other than infection occurring in an external accidental wound or from accidental food poisoning
- Participation in hazardous activities such as: scuba diving; bungee jumping; skydiving; hang gliding; ballooning; drag racing; driving a car fitted for competitive racing; aerial hunting; aerial skiing; or travel in an aircraft for the purpose of parachuting or otherwise exiting an aircraft while the aircraft is in flight except for the purpose of self-preservation
- Service in the armed forces of any country or international authority, except the United States National Guard
- Any nuclear reaction or release of nuclear energy. This includes the radioactive, toxic, explosive, or other hazardous or contaminating properties of radioactive matter
- The emission, discharge, dispersal, release, or escape of any solid, liquid, or gaseous chemical or biological agent
- Any incident related to travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger; or parachuting or otherwise exiting from such aircraft while the aircraft is in flight except for the purpose of self-preservation; or that does not have a valid Certificate of Airworthiness; or that is not flown by a pilot with a valid license to operate that aircraft; or which is owned, leased, controlled, or chartered by Wells Fargo; or in a device used for:
  - Testing or experimental purposes
  - Or by any military authority
  - Travel or designed for travel beyond the earth's atmosphere
  - Crop dusting, spraying, or seeding
  - Fire fighting
  - Sky diving

  - Hang gliding
  - Pipeline or power line inspection
  - Sky writing
  - Aerial photography or exploration
  - Racing, endurance tests, stunt or acrobatic flying
  - Any use that requires a special permit from the Federal Aviation Administration
- War, whether declared or undeclared; or act of war, insurrection, rebellion, riot, or terrorist act

Exclusion for intoxication

The BTA Plan will not pay benefits for bodily injuries received while the covered person was operating a motor vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.

Exclusion for commission of a felony

The BTA Plan will not pay benefits on behalf of a covered person for any loss caused or contributed to by the injured party committing or attempting to commit a felony.

Exclusion for drugs, poison, gas, or fumes

The BTA Plan will not pay benefits on behalf of a covered person for any loss caused by or contributed to by that person's voluntary intake or use by any means of:

- Any drug, medication, or sedative, unless it is taken or used as prescribed by a physician, or an "over the counter" drug, medication, or sedative taken as directed
- Poison, gas, or fumes

BTA Plan claims and appeals

Filing a claim

To file a claim under the BTA Plan, follow these steps:

1. You, your beneficiaries, or the executor of your estate should contact Employee Care as soon as possible after your death or after you sustain an injury or loss. Your Survivor Support Specialist will guide you through any claim forms you need to complete.
2. You, your beneficiaries, or the executor of your estate (as applicable) should submit a claim form and a completed physician's statement to the address below within 31 days of the date of the covered accident.

   Benefit Operations – Survivor Support
   PO Box 29781
   MAC S3837-01H
   Phoenix, AZ 85038
3. For a death claim, proof of death (including a required copy of the certified death certificate) must be submitted as soon as reasonably possible. For a dismemberment claim, proof of the accident causing dismemberment (including an accident report) is required to be submitted no later than 90 days after date of loss.

Claim determination

After you, your beneficiaries, or executor of your estate has completed the steps for filing a claim, MetLife processes your claim. MetLife may require additional documents to make a determination of payment. MetLife will make these requests directly to you, your beneficiaries, or the executor of your estate.

If the claim is approved, payment is made to you, your designated beneficiaries, or your estate.

You, your beneficiaries, or your executor will receive written notice from MetLife to inform you of the decision to approve or deny your claim (regardless of whether the claim is complete with all necessary information). This notification will be provided to you, your beneficiaries, or your executor within a reasonable period, not to exceed 90 days from the date MetLife received the claim, unless MetLife determines that special circumstances justify an extension of an additional 90 days, in which case MetLife will notify you or your beneficiaries before the expiration of the original 90-day period.

If part or all of the claim is denied, the notice includes:

- The reason for denial
- Reference to the pertinent BTA Plan provision on which the denial is based
- A description of any additional materials or information necessary to appeal the claim (and why it's necessary)
- Instructions for appealing the denied claim
- A statement of your right to appeal the decision and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of the claim on appeal

If you have questions about the claim determination, you can call MetLife at 1-866-549-2320. You also have the right to file an appeal without first calling the insurer.

Filing an appeal

When any claim is denied in whole or in part, you, your beneficiaries, or your executor have the right to submit a request for review to MetLife. Requests for review must be in writing and submitted within 60 days of receiving MetLife's decision. Submissions for a request for review need to be sent to:

MetLife
Group Life Claims
PO Box 6100
Scranton, PA 18505-6100

If you or your beneficiaries request a review, include the following:

- The reason you or your beneficiaries believe the claim was improperly denied
- Any written comments, documents, records, or other information deemed appropriate

Authorizing a representative

You have the right to have someone file an appeal review request on your behalf or represent you in the appeal process. To authorize someone to represent you, you must submit a written authorization to MetLife that includes the following:

- The name and address of the person authorized to represent you
- The purpose for which the individual is representing you
- The time period for which the individual will be your authorized representative
- The types of documents, records, or other items that may be requested of or released to the authorized individual

Note: Neither the insurer, the plan administrator, Wells Fargo, nor the plan is responsible for your authorized representative's disclosure of information provided to the authorized representative or that individual's failure to protect such information.

If you wish for an authorized representative to request and receive a copy of the SPD or plan document on your behalf, an authorization for representation statement as described above must be submitted to the plan administrator with the SPD or plan document request.

Appeal review and determination

MetLife's written decision is sent directly to you, your beneficiaries, or your executor within 60 days after MetLife's receipt of the review request. If an extension is required, MetLife will notify you, your beneficiaries, or your executor of the need for an extension before the end of the initial 60-day period. If MetLife denies the claim on appeal, the final written decision will state:

- The reason or reasons for the denial
- References specific to the BTA Plan provisions on which the denial is based
- Any voluntary appeal procedures offered by the BTA Plan
- A statement that you are entitled to receive — upon request and free of charge — all documents, records, and other information relevant to your claim for BTA Plan benefits
- A statement of your right to bring a civil action under Section 502(a) of ERISA

Wells Fargo delegates to MetLife (the insurer) the authority and discretion to interpret the plan and the policy and to decide questions of fact as necessary to determine if a benefit is payable under the plan. Wells Fargo reserves all other authority and discretion to administer the plan.

Legal action

There is a period of time after which you will not be entitled to take legal action. See the certificate for more information regarding that limitation.

Benefits when you're not working

BTA coverage may never be extended to cover you when you are not working because it is applicable only as described in the "BTA coverage" section on page 8-3.

When coverage ends

Coverage under the BTA Plan ends on the date:

- Your last day of employment takes place
- You no longer meet the eligibility requirements
- You die
- The BTA Plan is discontinued or terminated*

* For information on Wells Fargo's ability to amend, modify, or terminate the BTA Plan, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

Conversion

There is no conversion privilege for BTA coverage.

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Chapter 9: Accidental Death and Dismemberment Plan

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Information about Accidental Death and Dismemberment Plan provisions	HR Services & Support site
Information about enrollment	Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.
Information about premiums for the Accidental Death and Dismemberment Plan	HR Services & Support site
Questions about claims	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Questions about portability forms already submitted or existing ported policies	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Important Notifications and Disclosures," and "Appendix D: Leaves of Absence and Your Benefits" — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Accidental Death and Dismemberment Plan (the AD&D Plan).

The basics

General information

The SPD is a summary of provisions for the AD&D Plan and its underlying fully insured policy issued by Metropolitan Life Insurance Company (MetLife) and the corresponding Certificate of Insurance ("certificate"). For further details, contact Employee Care at 1-877-HRWELLS (1-877-479-3557) option 2, to request a copy of the certificate. Individual certificates are not available. The SPD and Group Policy Number 164933-1-G issued by MetLife, along with any applicable certificates, policy amendments, riders, and endorsements (collectively the "Group Policy"), constitute the official plan document for this AD&D Plan. If there are differences between the SPD and the Group Policy, the Group Policy governs your rights to benefits.

The AD&D Plan is a "welfare benefit plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Insurer and claims administrator

The AD&D Plan is insured by Metropolitan Life Insurance Company (MetLife). MetLife is the named fiduciary and has sole and complete discretionary authority to administer claims and interpret benefits under the AD&D Plan.

AD&D coverage

The AD&D Plan is an optional plan that you can elect to provide financial protection for you or your family if you or your covered family member is in a "covered accident" (as defined below) and within 365 days of the date of the covered accident any of the following happen. You (or your covered spouse, domestic partner, or dependent child, if you elect family coverage):

- Die
- Become paralyzed
- Suffer the loss of limb, speech, hearing, or sight
- Are in a coma that commences within 365 days of the date of a covered accident
- Suffer from brain damage
- Suffer from an accidental injury resulting from unavoidable exposure to the elements

A "covered accident," as used throughout this SPD, is defined as a sudden, unforeseeable, external event that results directly, and independently of all other causes, in a covered injury or covered loss and meets all of the following conditions:

- Occurs while the covered person is insured under this AD&D Plan
- Is not contributed to by disease, sickness, or mental or bodily infirmity
- Is not otherwise excluded under the terms of this SPD or the AD&D Plan policy

AD&D Plan at a glance

	Accidental Death and Dismemberment (AD&D)
Who pays the premium?	You, if you enroll
MetLife policy number	164933-1-G
Type of ERISA plan	Welfare benefit plan
Who's eligible	Regular and fixed term employees, and their eligible dependents
Who's not eligible	Intern and flexible employees and their dependents
Beneficiary	The person, persons, trust, or institution you designated (or if none, according to the "Payout if no surviving or designated beneficiary" section on page 9-6)
Cost	Based on the rate for the coverage level you elect
Coverage effective date	First of the month after one full calendar month of service from your date of hire or the effective date of your employment classification change from intern or flexible to regular or fixed term, provided that you enrolled during your new hire or newly eligible enrollment period and you are actively at work on the day coverage is scheduled to begin. First day of the year if enrolling for the first time during Annual Benefits Enrollment, provided that you are actively at work on January 1.
Cancel or decrease coverage	Cancel or decrease coverage anytime in Workday. Cancellations or decreased coverage changes are effective the first of the month following the change. Coverage cannot be canceled or decreased retroactively. If you want to enroll after your designated enrollment period or increase your coverage, you may do so only during Annual Benefits Enrollment (see the "Late enrollment" section on page 9-5 for more information).
Portability	You may port this to an individual policy. See the "Portability" section on page 9-13.
Coverage when you're not working	Coverage may continue when you are not actively at work during an approved leave of absence provided that you continue to pay premiums. See the "Benefits when you're not working" section on page 9-12.
AD&D Plan coverage levels	You may choose individual coverage from the following coverage levels: $75,000; $150,000; $300,000; $600,000
AD&D Plan death benefits	If family coverage is elected, your benefit is based on the individual coverage you've elected (same choices as above), while the spouse benefit (the amount you get if your spouse or domestic partner dies) is 50% of your elected coverage amount (not to exceed $300,000), and your dependent child benefit (the amount you get if your dependent child dies) is 15% of your elected coverage amount (not to exceed $90,000).
AD&D Plan dismemberment, paralysis, brain damage, and coma benefits	See the "Dismemberment, paralysis, brain damage, and coma benefits" section on page 9-10 for benefits available under the AD&D plan.

Who's eligible

Regular and fixed term Wells Fargo employees and their eligible dependents as described in "Chapter 1: Eligibility, Enrollment, and More" are eligible to participate in the AD&D Plan. Eligible employees may be covered both as an employee under their own Wells Fargo AD&D coverage election and as a dependent under their spouse, domestic partner, or parents Wells Fargo AD&D coverage election. Intern or flexible employees and their dependents are not eligible for coverage.

How to enroll

Initial enrollment

You may elect to enroll in AD&D coverage during your designated enrollment period if you are one of the following:

- A newly hired regular or fixed term employee
- An employee who has had an employment classification change from intern or flexible to regular or fixed term
- A rehired regular or fixed term employee

Refer to the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the timeframe and process for enrolling during your initial designated enrollment period.

If you enroll during your designated enrollment period, AD&D coverage generally becomes effective the first of the month following one full calendar month of service provided that you are actively at work on the day coverage is scheduled to begin. For more information, see the:

- "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More"
- "Delayed effective date" section on this page to understand the actively at work requirement

You may elect individual or family AD&D coverage and select one of the following coverage levels: $75,000, $150,000, $300,000, or $600,000. Refer to the "AD&D Plan benefits" section on page 9-7 for details on plan payments.

Enrollment in family AD&D coverage provides coverage for all eligible dependents. You do not need to separately enroll each individual dependent. Eligibility will be verified at the time a claim is filed, and the claim will be denied if your dependent is not eligible. Make sure your dependents are eligible and change your coverage level or drop your coverage when your dependents are no longer eligible. Otherwise, you will be paying for a benefit that you will not be able to use.

Late enrollment

If you do not enroll during your designated enrollment period, you must wait until the next Annual Benefits Enrollment period to make an enrollment election. If you did not elect family coverage to cover your eligible dependents when you first enrolled, you must wait until the next Annual Benefits Enrollment period to increase your coverage to the family level. If you elect or increase coverage during the Annual Benefits Enrollment period, your coverage will become effective the following January 1, subject to the actively at work provisions described under the "Delayed effective date" section below.

Delayed effective date

If you are not actively at work on the day coverage normally would begin, coverage will begin when you return to being actively at work. "Actively at work" means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to travel or allows you to work. Actively at work also includes any normally scheduled days off work, an observed holiday, or PTO.

Changing or canceling coverage

To enroll for the first time after your designated enrollment period, or if you wish to increase your AD&D coverage to cover your eligible dependents, see the "Late enrollment" section above.

You may decrease or cancel your coverage at any time throughout the year in Workday. Coverage will be decreased or canceled effective the first of the month following the change. Coverage cannot be canceled or changed retroactively.

Your obligation to drop ineligible dependents

It is your responsibility to change your election from "You + family" to "You only" when you no longer have any dependents eligible for Family coverage.

You must change your election from "You + family" to "You only" when one of the following occurs if you no longer have any eligible dependents:

- Your spouse or domestic partner is no longer eligible for AD&D coverage (for example, divorce, legal separation, termination of domestic partnership, or death)
- You no longer have any children eligible for AD&D coverage (for example, your child turns age 26, loss of foster parent or legal guardianship appointment, or any other event that results in a loss of eligibility)

Cost

You pay premiums for your AD&D Plan coverage through after-tax payroll deductions each pay period. Wells Fargo does not contribute toward payment of the premium. The amount you pay depends on the coverage level and option you elected.

Beneficiaries

If you die in a covered accident while covered under the AD&D Plan, benefits will be paid to the person or persons, trusts, or institutions you named as your beneficiary in Workday.

You will be asked to name one or more beneficiaries when you enroll. If you need to change your beneficiaries during the year, you may do so at any time in Workday.

When making a beneficiary decision, keep in mind the beneficiary may be a person, trust, charitable institution, or your estate. However, if a minor child is named as the beneficiary, the proceeds will go into a locked interest-bearing account until the child turns age 18. If a guardian of the child's estate or conservator of the child's estate has been appointed by the court, the benefits can be paid to the child's estate.

Note: If you enrolled in the family option, your covered dependents do not get to designate their beneficiaries. You are automatically the beneficiary. In the event that you die at the same time as your covered dependents, the death benefit for your covered dependents is paid to your estate.

Multiple beneficiaries

You may name more than one beneficiary for your death benefit under the AD&D Plan. In that case, the death benefit is shared equally among them — unless you designate otherwise. If one of the beneficiaries dies before you, the surviving beneficiaries receive the death benefit.

Primary and contingent (secondary) beneficiaries

You may name primary and contingent (secondary) beneficiaries for your benefits under the AD&D Plan. A primary beneficiary receives a death benefit after you die from a covered accident. If a primary beneficiary dies after you die but before receiving payment, the death benefit goes to the estate of the primary beneficiary. A contingent (secondary) beneficiary receives the death benefit only if the primary beneficiary dies before you die.

Changing beneficiaries

You may change beneficiaries under the AD&D Plan at any time in Workday. The change becomes effective on the date you make the change.

Payout if no surviving or designated beneficiary

If you do not choose a beneficiary — or if all of your designated primary and contingent (secondary) beneficiaries die before you — the death benefit under the AD&D Plan may be paid after your death to the following categories of individuals (in the order listed below) in which one or more individuals survive you:

1. Your surviving spouse or domestic partner[1]
2. Equally among your surviving biological and adopted children[2]
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

1. See the "Definitions relating to marital status" section on this page for more information.
2. Except that if any of the participant's children predecease him or her but leave descendants surviving, such descendants shall take by right of representation the share their parent would have taken, if living.

If you are not the biological or adoptive parent of your spouse's or domestic partner's child, but would like that child to receive benefits in the event of your death, you must properly designate that child as your beneficiary.

Definitions relating to marital status

For payment of a benefit if there are no surviving or designated beneficiaries, the following terms have the meanings assigned to them below:

- "Spouse" means the person to whom you are legally married on your date of death under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, or the person who was your current common-law spouse on your date of death in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages.
- "Domestic partner" means a person of the same or opposite gender who is not your spouse as defined above, that meets at least one of the following criteria on your date of death:
  - You and the person are joined in a civil union (or other similar formal relationship) on your date of death that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the union was created but is not denominated or recognized as a marriage under the laws of that state or country.
  - You and the person share a domestic partnership (or other similar formal relationship) on your date of death that is registered by a city, county, state, or country but is not denominated or recognized as a marriage under the laws of that city, county, state, or country.
  - You and the person both meet all of the following requirements:
    i. You and your domestic partner shared a single, intimate, committed relationship of mutual caring prior to your date of death and intended to remain in the relationship indefinitely.

ii. You resided together in the same residence and lived in a spouse-like relationship prior to your date of death.

iii. You and your domestic partner are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which you reside.

iv. Neither you nor your partner was married to another person under either federal, state, or common law, and neither is a member of another domestic partnership.

v. You and your partner were mentally competent to consent or contract.

vi. You were both at least 18 years old.

vii. You and your partner were financially interdependent, jointly responsible for each other's basic living expenses, and if asked, your partner is able to provide documentation for three of the following:

A. Joint ownership of real property or a common leasehold interest in real property

B. Common ownership of an automobile

C. Joint bank or credit accounts

D. A will that designates the other as primary beneficiary

E. A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other

F. Designation of one partner as holding power of attorney for health care decisions for the other

Assigning rights

You are not permitted to assign any of your rights under the AD&D Plan, including without limitation your right to designate beneficiaries.

AD&D Plan benefits

When AD&D benefits are payable

This AD&D policy is designed to pay a benefit if you or your covered family member is enrolled in the AD&D Plan and are in a "covered accident" (as defined in the "AD&D coverage" section on page 9-3), and within 365 days of the date of the covered accident any of the following happen. You (or your covered spouse, domestic partner, or dependent child, if you elect family coverage):

- Die
- Become paralyzed
- Suffer the loss of limb, speech, hearing, or sight
- Are in a coma that commences within 365 days of the date of a covered accident
- Suffer from brain damage
- Suffer from an accidental injury resulting from unavoidable exposure to the elements

No benefits are paid if the loss is caused or contributed to by illness or any of the causes listed in the "What is not covered" section on page 9-11.

Death benefit amount

The death benefit under the AD&D Plan depends on the coverage level you elected — $75,000, $150,000, $300,000, or $600,000. If family coverage is elected, the spouse benefit (the amount you get if your spouse or domestic partner dies) is 50% of your elected coverage amount (not to exceed $300,000), and your child benefit (the amount you get if your child dies) is 15% of your elected coverage amount (not to exceed $90,000).

Felonious assault benefit

If a covered accident, as defined by the plan, is the result of a felonious assault as described below, you are eligible for the AD&D Plan's applicable death benefit or dismemberment, paralysis, and coma benefits. The AD&D Plan will pay a benefit of 25% of the amount of coverage elected by the covered employee, up to a maximum of $100,000, if the insured's covered loss is caused by another person during a felonious assault as follows:

- An actual or attempted robbery or holdup
- An actual or attempted kidnapping
- Any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred

A felonious assault is defined as an assault committed during the commission of a felony or its equivalent as defined by the laws of the jurisdiction in which the act was committed. The act must be committed by someone other than:

- You
- A member of your immediate family (includes spouse, domestic partner, children and children's spouses, parents, siblings, grandparents, grandchildren, and any other member of your household or your dependents' households)
- A Wells Fargo employee

Hospital stay benefit

The AD&D Plan will pay this benefit if:

- Proof is received that you or a covered dependent is confined in a hospital as a result of an accidental injury that is the direct cause of such confinement independent of other causes
- This benefit is in effect on the date of the injury

The AD&D Plan will pay an amount for each full month of hospital confinement equal to the lesser of:

- 1% of the amount of coverage elected by the covered employee
- $2,500

The AD&D Plan will pay this benefit on a monthly basis beginning on the fifth day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a prorated basis for any partial month of confinement.

The AD&D Plan will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

Seat belt and airbag benefit

The death benefit will be increased by an additional 20% of the amount of coverage elected by the covered employee, not to exceed $100,000, but no less than $1,000, if a loss of life occurs due to a covered accident while properly using a seat belt in a passenger vehicle. No benefit increase is payable if the official accident report is either not provided or indicates that no seat belt was worn.

The death benefit will be increased by an additional 10% of the amount of coverage elected by the covered employee, not to exceed $10,000, but no less than $1,000, if loss of life occurs due to a covered accident while positioned in a seat protected by a properly functioning and properly deployed airbag in a passenger vehicle.

Home alteration and vehicle modification

The benefit will be increased by 10% of the amount of coverage elected by the covered employee, not to exceed $100,000, if loss, other than loss of life, occurs due to a covered accident and the covered person requires home alteration or vehicle modification within one year of date of the covered accident. This benefit will be payable if all of the following conditions are met:

- Before the date of the covered accident causing such covered loss, the covered person did not require the use of any adaptive devices or adaptation of residence, vehicle, or both.
- As a direct result of such covered loss, the covered person now requires such adaptive devices or adaptation of residence, vehicle, or both to maintain an independent lifestyle.
- The covered person requires home alteration or vehicle modification within one year of the date of the covered accident.

Rehabilitation benefit

The benefit is payable to the covered employee or covered dependent experiencing the loss and will pay an amount equal to the lesser of the actual charges incurred for rehabilitative physical therapy; 10% of the full amount shown in the schedule of benefits in the certificate of coverage; or $10,000.

Therapeutic counseling

The therapeutic counseling benefit pays an additional benefit equal to the charges for therapeutic counseling provided to a covered employee or covered dependent, subject to the condition that the counseling was prescribed within 90 days of the date of the covered loss, and was provided within one year of the date of the covered loss. The benefit will pay an amount equal to the lesser of the actual charges incurred for therapeutic counseling; or 10% of the amount of coverage elected by the covered employee; or $10,000.

Repatriation expense

If you or a covered dependent dies as a result of a covered accident, the plan will pay this additional benefit if:

- The plan pays a benefit for loss of life under the accidental death and dismemberment insurance benefit
- Proof of death is provided and confirms the death occurred at least 100 miles from the covered employee's primary residence

The plan will pay an additional benefit equal to the charges incurred for the preparation and transportation of the deceased's body to the city of the deceased's primary residence; not to exceed $5,000.

Additional benefits

Spouse or domestic partner education

If you die as a result of a covered accident, the AD&D Plan will pay this additional spouse or domestic partner education benefit if the plan receives proof that:

- On the date of your death, your spouse or domestic partner was enrolled as a full-time student in an accredited school
- Within 12 months after the date of your death, your spouse or domestic partner enrolls as a full-time student in an accredited school

The AD&D Plan will pay an amount equal to the tuition charges incurred for a period of up to one academic year, not to exceed the lesser of 5% of the amount of coverage elected by the covered employee or $5,000. The AD&D Plan may require proof of the spouse's or domestic partner's continued enrollment as a full-time student during the period for which a benefit is claimed.

Child education benefits

If you or your spouse or domestic partner dies as a result of a covered accident, the AD&D Plan will pay this additional child education benefit if the plan receives proof that on the date of death a child was:

- Enrolled as a full-time student in an accredited college, university, or vocational school above the 12th-grade level
- At the 12th-grade level and, within one year after the date of death, enrolls as a full-time student in an accredited college, university, or vocational school

For each child who qualifies for this benefit, the AD&D Plan will pay an amount equal to the tuition charges incurred for a period of up to four consecutive academic years, not to exceed the lesser of an academic year maximum of $10,000 or up to 5% of the amount of coverage elected by the covered employee.

In the event that both you and your spouse or domestic partner die under circumstances such that each death would cause a payment to be made for a child under this additional benefit, the following rules apply:

- Payment will not exceed the lesser of the academic year maximum of $20,000 or 5% of the amount of coverage elected by the employee plus 5% of the spouse or domestic partner coverage amount (50% of the coverage elected by the employee).
- In no event will the amount paid under all child education benefits exceed the amount of tuition incurred.

The AD&D Plan may require proof of the child's continued enrollment as a full-time student during the period for which a benefit is claimed.

The AD&D Plan will pay this benefit semi-annually when provided proof that tuition charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date of death and there is no child who could qualify for it, the AD&D Plan will pay $1,000 to your beneficiary in one sum.

Child care center benefit

If you or your spouse or domestic partner dies as a result of a covered accident, the AD&D Plan will pay this additional child care benefit if the plan receives proof that:

- On the date of death, a child was enrolled in a child care center
- Within 12 months after the date of death, a child was enrolled in a child care center

Child care center is defined as a facility that:

- Is operated and licensed according to the law of the jurisdiction where it is located
- Provides care and supervision for children in a group setting on a regularly scheduled and daily basis

For each child who qualifies for this benefit, the AD&D Plan will pay an amount equal to the child care center charges incurred for a period of up to five consecutive years, not to exceed the lesser of an annual maximum of $5,000 or an overall maximum of 2% of the amount of coverage elected by the covered employee.

In the event that both you and your spouse or domestic partner die under circumstances such that each death would cause a payment to be made for a child under this additional benefit, the following rules apply:

- Payment will not exceed the lesser of the annual maximum of $10,000 or 2% of the amount of coverage elected by the covered employee plus 2% of the spouse or domestic partner coverage amount (50% of the coverage elected by the employee).
- In no event will the amount paid under all child care benefits exceed the amount of child care charges incurred.

The AD&D Plan will not pay for child care center charges incurred after the date a child attains age 13.

The AD&D Plan may require proof of the child's continued enrollment in a child care center during the period for which a benefit is claimed.

The AD&D Plan will pay this benefit quarterly when the plan receives proof that child care center charges have been paid.

Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date you or your spouse or domestic partner dies and there is no child who could qualify for it, the AD&D Plan will pay $1,000 to your beneficiary in one sum.

Common accident benefit

The benefit will increase the loss of life benefit payable for the covered spouse or domestic partner to 100% of the employee's elected coverage amount if both the employee and their covered spouse or domestic partner die within 365 days, and they die directly, and independently of all other causes, from a common accident and are survived by one or more dependent children.

"Common accident" means the same covered accident or separate covered accidents that occur within the same 24-hour period.

Dismemberment, paralysis, brain damage, and coma benefits

If you or your covered family member is in a covered accident (as defined in the "AD&D coverage" section on page 9-3) and within 365 days of the covered accident you (or your covered spouse, domestic partner, or dependent child if you elect family coverage) lose a limb, sight, hearing, or speech, are paralyzed, have brain damage, or if a coma commences within 365 days from the date of the covered accident while you are covered under the AD&D Plan, you will receive a benefit according to the following schedule:

	Loss	Amount paid
Dismemberment	Both hands or both feet or sight in both eyes; speech and hearing in both ears; or any two or more such losses in any combination	100% of covered amount*
	One hand, one foot, sight in one eye, speech, or hearing in both ears	50% of covered amount*
	Thumb and index finger of the same hand, all four fingers of same hand, or all toes of same foot	25% of covered amount*
Total paralysis	Both upper and lower limbs (quadriplegia)	100% of covered amount*
	Both upper or both lower limbs (paraplegia)	75% of covered amount*
	An upper and lower limb on one side of the body (hemiplegia)	50% of covered amount*
	One upper or lower limb (uniplegia)	50% of covered amount*
Brain damage	Brain damage resulting from a covered accident	100% of covered amount*
Coma	A coma resulting from a covered accident	1% of covered amount* (1% will be paid monthly, continuing for 11 consecutive months, with the remaining balance paid as a lump sum on the 12th month)

* Covered amount is equal to the coverage level that you elected ($75,000, $150,000, $300,000, or $600,000). If family coverage is elected, your covered amount is equal to the coverage level you've elected, while the covered amount for your spouse or domestic partner is half of your elected coverage level (not to exceed $300,000), and the covered amount for your dependent child is 15% of your elected coverage level (not to exceed $90,000).

Covered losses, total paralysis, brain damage, and coma are defined as follows:

- Loss of a hand or foot means complete severance through or above the wrist or ankle joint.
- Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye, or the field of vision must be less than 20 degrees.
- Loss of speech means a loss of speech continuing for six consecutive months, after which a physician must determine the loss to be entire and irrecoverable.
- Loss of hearing means a loss of hearing continuing for six consecutive months, after which a physician must determine the loss to be entire and irrecoverable.
- Loss of a thumb and index finger of the same hand or four fingers of the same hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
- Loss of toes means complete severance through the metatarsal phalangeal joint.
- Paralysis or paralyzed means total loss of use of a limb. A physician must determine the loss of use to be complete and irreversible.
- Severance means the complete and permanent separation and dismemberment of the part from the body.
- Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least five days, and persist for 12 consecutive months after the date of the accidental injury.
- Coma means a profound state of unconsciousness that resulted directly and solely due to a covered accident and from which the covered person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a covered injury, unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that covered accident.

Other AD&D Plan provisions

The following provisions apply to death, dismemberment, paralysis, and coma benefits, resulting from a covered accident:

- Benefits are paid if death, dismemberment, or paralysis occurs within 365 days following the date of the covered accident.
- Benefits are paid if a coma commences within 365 days of the covered accident.

War risk coverage

War risk coverage provides benefits for covered accidents caused by war or acts of war worldwide when in a country other than the United States and war occurs. The following countries are also excluded from these benefits: Afghanistan, Algeria, Burkina Faso, Burundi, Central African Republic, Cote d'Ivoire, Democratic Republic of the Congo, Egypt, Eritrea, Ethiopia, Guinea, Iran, Iraq, Libya, Madagascar, Mali, Nigeria, North Korea, Pakistan, Somalia, South Sudan, Sudan, Syria, Tajikistan, Yemen, and Zimbabwe.

Terrorism coverage

A terrorist act is considered a felony. Please refer to the "Felonious assault benefit" section on page 9-7.

What is not covered

The AD&D Plan will not pay benefits for any loss caused or contributed to by:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity
- Infection, other than infection occurring in an external accidental wound or from food poisoning
- Suicide or attempted suicide
- Intentionally self-inflicted injury
- Service in the armed forces of any country or international authority, except the United States National Guard
- Any incident related to travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger; or travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight; or parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation; or travel in an aircraft or device used:
  - For testing or experimental purposes
  - By or for any military authority
  - For travel or designed for travel beyond the earth's atmosphere
- Committing or attempting to commit a felony
- The voluntary intake or use by any means of any drug, medication, or sedative, unless it is taken or used as prescribed by a physician; or an "over the counter" drug, medication, or sedative taken as directed; or poison, gas or fumes
- Bodily injuries received while insured person was operating a motor vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit
- War, whether declared or undeclared; or act of war, insurrection, rebellion, riot, or active participation in a riot

AD&D Plan claims and appeals

Filing a claim

To file a claim under the AD&D Plan, follow these steps:

1. You, your beneficiary, or the executor of your estate should contact Employee Care as soon as possible after sustaining an injury or loss. Your Survivor Support Specialist will guide you through any claim forms you need to complete.
2. You, your beneficiary, or the executor of your estate (as applicable) should submit a claim form and a completed physician's statement to the address below within 31 days of the date of the covered accident.

   Benefit Operations – Survivor Support
   PO Box 29781
   MAC S3837-01H
   Phoenix, AZ 85038
3. For a death claim, proof of death (including a required copy of the certified death certificate) must be submitted as soon as reasonably possible. For a dismemberment claim, proof of the accident causing dismemberment (including an accident report) is required to be submitted no later than 90 days after date of loss.

Claim determination

After you, your beneficiary, or executor of your estate has completed the steps for filing a claim, MetLife processes your claim. MetLife may require additional documents to make a determination of payment. MetLife will make these requests directly to you, your beneficiary, or your estate.

If the claim is approved, payment is made to you, your designated beneficiary, or your estate.

You, your beneficiaries, or your executor will receive written notice from MetLife to inform you of the decision to approve or deny your claim (regardless of whether the claim is complete with all necessary information). This notification will be provided to you, your beneficiaries, or your executor within a reasonable period, not to exceed 90 days from the date MetLife received the claim, unless MetLife determines that special circumstances justify an extension of an additional 90 days, in which case MetLife will notify you, your beneficiaries, or your executor before the expiration of the original 90-day period.

If part or all of the claim is denied, the notice includes:

- The reason for denial
- Reference to the pertinent AD&D Plan provision on which the denial is based
- A description of any additional materials or information necessary to appeal the claim (and why it's necessary)
- Instructions for appealing the denied claim
- A statement of your right to appeal the decision and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of the claim on appeal

If you have questions about the claim determination, you can call MetLife at 1-866-549-2320. You also have the right to file an appeal without first calling the insurer.

Filing an appeal

When any claim is denied in whole or in part, you, your beneficiaries, or your executor have the right to submit a request for review to MetLife. Requests for review must be in writing and submitted within 60 days of receiving MetLife's decision. Submissions for a request for review need to be sent to:

MetLife Group Life Claims
PO Box 6100
Scranton, PA 18505

If you, your beneficiaries, or your executor request a review, include the following:

- The reason you, your beneficiaries, or your executor believe the claim was improperly denied
- Any written comments, documents, records, or other information deemed appropriate

Authorizing a representative

You have the right to have someone file an appeal review request on your behalf or represent you in the appeal process. To authorize someone to represent you, you must submit a written authorization to MetLife that includes the following:

- The name and address of the person authorized to represent you
- The purpose for which the individual is representing you
- The time period for which the individual will be your authorized representative
- The types of documents, records, or other items that may be requested of or released to the authorized individual

Note: Neither the insurer, the plan administrator, Wells Fargo, nor the plan are responsible for your authorized representative's disclosure of information provided to the authorized representative or that individual's failure to protect such information.

If you wish for an authorized representative to request and receive a copy of the SPD or plan document on your behalf, an authorization for representation statement as described above must be submitted to the plan administrator with the SPD or plan document request.

Appeal review and determination

MetLife's written decision is sent directly to you, your beneficiaries, or your executor within 60 days after MetLife's receipt of the review request. If an extension is required, MetLife will notify you, your beneficiaries, or your executor of the need for an extension before the end of the initial 60-day period. If MetLife denies the claim on appeal, the final written decision will include:

- The reason or reasons for the denial
- References specific to the AD&D Plan provisions on which the denial is based
- Any voluntary appeal procedures offered by the AD&D Plan
- A statement that you are entitled to receive — upon request and free of charge — all documents, records, and other information relevant to your claim for AD&D Plan benefits
- A statement of your right to bring a civil action under Section 502(a) of ERISA

Wells Fargo delegates to MetLife (the insurer) the authority and discretion to interpret the plan and the policy and to decide questions of fact as necessary to determine if a benefit is payable under the Plan. Wells Fargo reserves all other authority and discretion to administer the plan.

Legal action

There is a period of time after which you will not be entitled to take legal action. See the certificate for more information regarding that limitation.

Benefits when you're not working

You must continue paying the premiums to maintain AD&D coverage while you are on a leave of absence. If coverage is canceled due to nonpayment of premiums while you are on an approved leave of absence, you must wait until the next Annual Benefits Enrollment period to reenroll. Coverage will begin on the first day of the plan year following Annual Benefits Enrollment, provided that you are actively at work on the day coverage is scheduled to begin. (See "Appendix D: Leaves of Absence and Your Benefits" for more information.)

When coverage ends

Coverage under the AD&D Plan ends on the last day of the month in which one of the following events occurs:

- Your last day of employment or the last day of your severance eligibility period under the Wells Fargo & Company Severance Plan, whichever occurs later.[1]
- You no longer meet the eligibility requirements.
- You voluntarily make a permitted election to drop coverage. (**Exception:** If you make an election to drop coverage during Annual Benefits Enrollment, that coverage ends December 31 of the year in which the Annual Benefits Enrollment election was made.)

Coverage under the AD&D Plan will also end if you stop paying the required premiums or if the AD&D Plan is discontinued or terminated regardless of any of the events noted above.[2]

1. If you are rehired by Wells Fargo as a regular or fixed term employee and your first day of reemployment occurs during your severance eligibility period, any benefits that are in effect on the day before your rehire will continue as a rehired employee. For more information, see the "Rehired employees" section in "Chapter 1: Enrollment, Eligibility, and More".

2. For information on Wells Fargo's ability to amend, modify, or terminate the AD&D Plan, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

If you die, coverage ends on your date of death.

Coverage for your covered dependents ends when they no longer meet the eligibility requirements. Coverage for all of your covered dependents also ends upon your death or when your coverage ends, but they may have the option of porting their policy, as described below.

Portability

The coverage under the AD&D Plan may be ported to an individual policy after you terminate employment or no longer meet eligibility requirements with Wells Fargo, provided that you were enrolled in the AD&D Plan at the time of coverage termination. Your porting application and first premium must be sent to MetLife within 31 days after the termination of coverage.

Who's eligible for porting

Employees, covered spouses or covered domestic partners, and covered dependents may elect to port AD&D coverage to an individual policy when the coverage, or any portion of the coverage, ends. Situations that allow you or your covered dependents to port to an individual policy include:

- Your Wells Fargo employment is terminated.
- You retire.
- You no longer meet eligibility requirements.
- Your covered dependents no longer meet eligibility requirements.
- The AD&D Plan terminates.

How porting works

Porting works as follows:

- The ported policy is a standard AD&D policy; therefore, the ported policy may not include all of the benefits of your coverage through the AD&D Plan and may exclude conditions that are covered under the AD&D Plan. Contact MetLife for details. The ported policy is not part of the AD&D Plan and is not part of any employee benefit plan sponsored by Wells Fargo.
- You and all of your covered dependents may port a minimum of $25,000 of coverage in increments of $1,000, up to your current coverage amount but not to exceed $250,000.
- Premiums for the ported policy are at current MetLife ported rates and are based on age and amount of coverage.
- Your porting application and first premium must be sent to MetLife within 31 days after the termination of coverage. Coverage takes effect, subject to payment of the first premium, on the later of:
  - The date coverage under the Wells Fargo AD&D Plan terminates
  - The date you apply for ported coverage

How to apply

Upon termination of group coverage through Wells Fargo, you should receive information directly from MetLife regarding portability of coverage. If you do not receive this information within 14 days, contact MetLife at 1-866-549-2320.

You must complete the portability form and mail it with the first premium payment to MetLife within 31 days from the date group coverage ends through Wells Fargo.

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Chapter 10: Short-Term Disability Plan

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Contacts

To file a claim or for information about your existing claim	Claims Administrator Lincoln Financial Group (Lincoln) 1-866-213-2937 mylincolnportal.com (company code: wells)
To fax documentation about your claim	Lincoln 1-866-214-7839
Information about the Short-Term Disability Plan	HR Services & Support site Lincoln 1-866-213-2937 wellsfargo@lfg.com

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Important Notifications and Disclosures," and "Appendix D: Leaves of Absence and Your Benefits" — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Short-Term Disability Plan (the STD Plan) that covers regular and fixed term Wells Fargo employees.

The basics

General information

The STD Plan provides short-term disability coverage on a self-insured basis and is classified as a "welfare benefit plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The STD Plan provides you with short-term disability benefits if you have a medically certified health condition and are unable to perform some or all of your job duties for more than seven consecutive calendar days (the "STD waiting period"). (Please review the "Medically certified health condition definition" section on page 10-8.) As it pertains to the waiting period, if you are working a partial schedule as a result of a medically certified health condition, you are not eligible to receive STD benefits until you have been out of work completely for more than seven consecutive calendar days (see the reference to "STD waiting period" in the "How the STD Plan works" on page 10-7).

Generally, STD benefits replace either 65% or 100% of your covered pay, referred to as "salary" in the Benefits section of Workday, per week, depending on your completed years of service, for up to 25 weeks following your completion of the seven consecutive day STD waiting period. (Please review the "STD benefits schedule" on page 10-11.) STD benefits coordinate with other sources of income you receive so that your STD benefit combined with other sources of income is never more than 100% of your predisability covered pay.

Wells Fargo provides short-term disability benefits through two different plans: the STD Plan and the Wells Fargo & Company Short-Term Disability Top-Up Plan (the "STD Top-Up Plan"). While most STD benefits are paid through the STD Plan up to certain plan limits, some employees may receive a portion of their benefits from the STD Top-Up Plan. This is necessary for technical reasons, but if this applies to you then you will receive only one check that will include all your STD benefits. However, it is important to note that the provisions of the STD Top-Up Plan are not part of the SPD or SMM for the STD Plan and the STD Plan provisions are not part of the SPD for the STD Top-Up Plan.

Claims administrator

The STD Plan is self-insured, and Lincoln Financial Group (Lincoln) is the claims administrator providing administrative claims services. Lincoln has full discretionary authority to administer and interpret the STD Plan.

Who's eligible

Eligible employees

You are eligible for the STD Plan if you are a regular or fixed term Wells Fargo employee as described in "Chapter 1: Eligibility, Enrollment, and More."

Ineligible employees

You are not eligible to participate in the STD Plan if you are:

- Classified as an intern or flexible employee.
- An employee of an affiliate not participating in the STD Plan.
- An employee who is classified as an international employee.
- A person whom Wells Fargo classifies as an independent contractor or any other status by which you are not treated as a common-law employee of Wells Fargo for purposes of withholding taxes, regardless of your actual status. (This applies to all periods of such service of an individual who is subsequently reclassified as an employee, whether the reclassification is retroactive or prospective.)
- A regular or fixed term employee who is on certain types of leaves of absence (see "Appendix D: Leaves of Absence and Your Benefits")

Cost and funding

Wells Fargo pays the entire cost of your coverage under the STD Plan.

Benefits are funded through the Wells Fargo & Company Short-Term Disability Plan Trust.

How to enroll

You are automatically enrolled in the STD Plan if you are one of the following:

- A newly hired regular or fixed term employee
- An employee who has had an employment classification change to a regular or fixed term position
- A rehired regular or fixed term employee

When coverage begins

New hire or newly eligible

STD coverage begins the first of the month following one full calendar month of service in a regular or fixed term position, subject to the requirement that you be actively at work on your first day of coverage. If you are not actively at work the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a regular or fixed term position. For more information, see the "Actively at work definition" section on this page.

If you were previously employed by a company that was acquired by or merged with Wells Fargo, certain transition rules may apply to your participation in the STD Plan when you first become an employee as a result of the acquisition or merger.

Rehired employees

If you are rehired into a regular or fixed term position within the six-month period following your termination date, your STD coverage begins on your rehire date provided that you were covered by the STD Plan at the time of your termination. If you had not yet completed one full calendar month of service at the time of your termination, your STD coverage will begin on the first of the month following one full calendar month of service after your rehire, subject to the requirement that you are actively at work on your first day of coverage as described below.

If you are rehired into a regular or fixed term position after the six-month period following your termination date, your STD coverage will begin on the first of the month following one full calendar month of service after your rehire, subject to the requirement that you are actively at work on your first day of coverage as described below.

In either case, if you are not actively at work the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a regular or fixed term position. For more information, see the "Actively at work definition" section on this page.

If you are a Wells Fargo retiree who was rehired on or after January 1, 2011, in a regular or fixed term position, your STD coverage begins on your first day of active employment in a regular or fixed term position.

Employment classification changes

If you become eligible for STD coverage as a result of an employment classification change, your coverage becomes effective the first of the month following one full calendar month of service in your new employment classification. You must also be actively at work the day coverage begins. If you are not actively at work the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a regular or fixed term position. For more information, see the "Actively at work definition" section below.

If you change employment classification from regular or fixed term to an intern or flexible employee, your STD coverage will end as of the classification change date. If you are receiving STD benefits as of your classification change date, you will continue to receive STD benefits until you are released to return to work or you are no longer approved for STD benefits.

Actively at work definition

"Actively at work" means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to work or travel or allows you to work. Actively at work also includes any normally scheduled days off work, observed holidays, Paid Time Off (PTO), and other paid time away that is recognized under Wells Fargo's time away policies (except for Military Duty time away).

When coverage ends

Your STD coverage ends on the earliest of the following dates:

- The day your last day of employment takes place
- The day you transfer to an ineligible employment classification or position
- The first day you are away from work for a reason other than PTO, other paid time away that is recognized under Wells Fargo's time away policies, or an authorized leave during which eligibility for STD Plan participation continues (see the "Leave of absence" section on page 10-5)
- The day you begin a Military Leave or time away, Job Search Leave, Preferential Hiring Leave, or unpaid Administrative Leave
- The day you die
- The day the STD Plan is discontinued or terminated
- The day you begin severance benefits under the Wells Fargo & Company Severance Plan on or after 1/1/2022

For information on Wells Fargo's ability to amend, modify, or terminate the STD Plan at any time and for any reason, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

Coverage when you're not working

Leave of absence

Eligibility for STD coverage continues during the following types of leaves of absence*:

- Medical Leave, provided that:
  1. You were eligible to participate in the STD Plan as of your last day worked.
  2. You have not received the maximum amount of STD benefits as shown on the "STD benefits schedule" on page 10-11.
- Workers' Compensation Leave**
- Family Leave
- Paid Administrative Leave
- Personal Leave
- Parental Leave
- Critical Caregiving Leave
- Job-Protected Paid Leave
- Non-working Notice Leave

You are not eligible for STD coverage during a Military Leave, Job Search Leave, Preferential Hiring Leave, unpaid Administrative Leave, or Job-Protected Unpaid Leave. This means that if you become disabled while on one of these leaves, you will not be eligible for STD benefits.

* If your claim for STD benefits has been denied and you continue to remain out of work due to your medically certified health condition (the health condition that was the basis for your denied claim) or for any other reason, you are not eligible to file a subsequent claim for STD benefits for this same health condition (excluding pregnancy) while you remain out of work even if you are on an approved leave of absence. However, you have the right to appeal the denied claim; see the "Filing an appeal" section on page 10-15.

**Wells Fargo provides the Texas Injury Benefit Plan, rather than Workers' Compensation, for Texas employees who have a work-related injury or illness. For Texas employees, references to "Workers' Compensation" shall mean the "Wells Fargo Texas Injury Benefit Plan."

How STD benefits coordinate with leave of absences

The STD Plan provides pay continuation if you have a medically certified health condition and are unable to perform some or all of you job duties for more than seven consecutive calendar days. Generally, you will be on a leave of absence that runs concurrently to your short-term disability benefits. A leave of absence is not part of the STD Plan and has different requirements, including different forms and deadlines. The discussion of leaves in this section and the chart below is for informational purposes only and is not part of the STD plan or any other ERISA benefit sponsored by Wells Fargo.

For a	You'll need to provide:
Medical Leave of Absence	A Certification of Health Care Provider (DOC) form confirming that you are medically unable to work. Provide documentation, including the required certification, within 15 calendar days of the leave administrator's request. You may be required to provide recertification on a periodic basis. **Note:** If you submit a claim for short-term disability (STD) benefits concurrently with a Medical Leave request, you and your health care provider must provide additional medical documentation to support your STD claim (see information about medical documentation under the "Proof of your disability" on page 10-8). The Certification of Health Care Provider form submitted with your medical leave request does not provide enough information to support a short-term disability claim. An approved medical leave is unpaid until a short-term disability claim is approved.

Short-Term Disability claim	You must provide additional medical documentation described in "Proof of your disability" on page 10-8 to support your STD claim. Authorization forms: • Lincoln Authorization to Obtain and Release Information (PDF) • Kaiser Authorization to Disclose Health Information (PDF). The Certification of Health Care Provider form is used solely for the purpose of approving a medical leave, which is unpaid. In order to recieve Short-Term Disability pay during your medical leave, Lincoln will provide you with an Authorization to Obtain and Release Information form that authorizes your provider to share medical records with Lincoln Financial to evaluate your eligibility for STD pay. You will need to sign the authorization form and send it to Lincoln or provide directly to your treating provider. It is your responsibility to ensure that Lincoln receives the information in a timely manner. When medical records are not received timely, any STD payments you may be eligible for may be delayed. See the "Proof of your disability" section on page 10-8 for more details.
Parental Leave	If you file a claim for maternity Short-Term Disability benefits, then Parental leave supplements the benefits you may be eligible to receive under the STD Plan, if you meet the requirements for Parental Leave. Generally, parental leave runs concurrently with Short-Term Disability benefits. Lincoln will provide you with a Certificate of Care form for Parental Leave where you will self-designate as a primary or nonprimary caregiver. For more infomation on how the STD Plan coordinates with Parental Leave, see the "STD benefit amount" section on page 10-12.

How to file a claim for STD benefits

1. Call your supervisor

If you are unable to work your regular work schedule, you must speak to your supervisor immediately. If you are unable to personally speak to your supervisor, have someone else make the call. You don't need to share any medical information with your supervisor, but you should keep in regular contact with them about your leave status, including any extension of your leave, work restrictions, return to work date, and requested accommodations, if any.

If you are aware of an impending leave because of a planned medical procedure, you should provide your supervisor with at least 30 days advance notice.

2. Call Lincoln

To file a claim for STD benefits for a health condition that is not due to a work-related illness or injury, you must file a claim with Lincoln. There are two ways to file your claim for STD benefits:

1. **Call our claims administrator, Lincoln, at** 1-866-213-2937.
2. **File online at Lincoln at** mylincolnportal.com**.** First-time users will need to establish a username and password by following the prompts on the screen. The company code for Wells Fargo is "wells."

You may report your claim for disability benefits up to 30 days in advance of the date your leave is to begin.

Proof of your disability is required for all claims and must be received by Lincoln within the designated time frame described in the "Proof of your disability" section starting on page 10-8. Proof may include medical records, test results, or hospitalization records as Lincoln deems necessary. If Lincoln has not received valid medical proof of your disability within the designated time frame, your request for STD benefits will be denied. For more information, see the "STD benefits schedule" on page 10-11 and the "Proof of your disability" section on page 10-8.

If your health condition is due to a work-related illness or injury, you must contact a Risk & Insurance Management Representative by calling 1-877-HRWELLS (1-877-479-3557), option 2, 3, 3 to file a separate Workers' Compensation claim.

If you return to work, and within 30 calendar days you miss work again because of a recurrence of your medically certified health condition, immediately contact all of the following:

- Your supervisor
- Lincoln, at 1-866-213-2937

For more information, see the "Recurrent condition" section on page 10-10.

A claim for STD benefits and Workers' Compensation for the same condition will be coordinated. Workers' Compensation is considered the primary source of income continuation if you have a health condition that is payable under both Workers' Compensation and the STD Plan. STD benefits will be reduced by your Workers' Compensation benefits. (See the "Deductible sources of income" section on page 10-12 for more information.) Claims for STD benefits are reviewed independent of claims for Workers' Compensation benefits.

3. Get the forms you need

The forms referenced below are available by calling Lincoln at 1-866-213-2937.

Please include your Lincoln claim number and your first and last name on all correspondence sent to Lincoln. This allows Lincoln to expedite the review of any correspondence concerning your request for STD benefits.

Required forms

Complete the Authorization to Obtain and Release Information form and fax it to Lincoln at 1-866-214-7839 or mail it to the following address:

Lincoln Financial Group
Disability Claims
PO Box 2578
Omaha, NE 68172-9688

To expedite the processing of your claim, Lincoln may need to contact your physician to obtain medical information concerning your disability. Your physician cannot share medical information concerning your disability unless the authorization is on file with Lincoln. Failure to provide a completed authorization form may result in the denial of your claim for STD benefits.

While Lincoln will make attempts on your behalf to obtain your medical records, it is your responsibility to provide the required documentation. Your failure to provide the medical information concerning your disability when required may result in the denial of your claim for STD benefits.

4. Provide valid medical information

The medical information you provide in support of your claim must be accurate. If the information is not accurate or the signature of the health care provider is not valid as determined by Lincoln, your claim for STD benefits will be denied or discontinued, you will be disqualified from participating in the STD Plan, and you may be subject to further disciplinary action, including termination of employment.

5. Timely action required

Your STD benefits payments will be denied or discontinued if you or your health care provider does not supply, by the due date, all of the information about your condition requested by Lincoln.

Note: If you are eligible for benefits under both the STD Plan and the STD Top-Up Plan, you only need to file one claim for STD benefits. The claims administrator of each plan will coordinate the claim with the other plan, if necessary.

How the STD Plan works

STD waiting period

You may be eligible for STD benefits after you complete the STD waiting period. The STD waiting period is the seven-consecutive-calendar-day period beginning on the initial date of your medically certified health condition.

If you begin your leave with a reduced work schedule, the hours you have missed will not apply toward the waiting period.

If you return to work and attempt to complete one scheduled workday before the end of the STD waiting period, but you are unable to work at least half of your regularly scheduled workday due to your medically certified health condition, then the STD waiting period will be considered to have been uninterrupted. If you work one full day during your waiting period, your waiting period will start over.

Your time away from work during the STD waiting period is subject to Wells Fargo's time away programs, including required use of your accrued, unused Paid Time Off (PTO) or paid sick time (PST), as applicable during the STD waiting period for any scheduled work hours you miss. If you do not have accrued PTO or PST available, and your time away from work is not otherwise subject to income replacement under Wells Fargo's time away programs, the STD waiting period will be unpaid unless your business group allows employees to use unaccrued PTO from their current year's unaccrued PTO, in which case you may use PTO allowance in accordance with your business group's policy and other paid time away (with the exception of military duty).

If you are requesting STD benefits due to the birth of a child and you are the primary caregiver and have met the eligibility requirements for Parental Leave, you do not need to use PTO or PST to cover the STD waiting period. However, if you are not the primary caregiver and defer your Parental Leave to a later date or you are not yet eligible for Parental Leave, then the previous paragraph applies to you.

Qualifying for STD benefits

To qualify for STD benefits, you must:

- Be eligible for coverage under the STD Plan.
- Be actively at work on the scheduled day before the onset of disability or on an approved leave of absence that is recognized by the STD Plan (for example, a Medical Leave, Family Leave, Workers' Compensation Leave, or Personal Leave).
- Be considered disabled under the STD Plan; that is, you must have a medically certified health condition that lasts longer than the STD waiting period and prevents you from performing the essential duties of your job.
- Be under the care of an approved care provider.
- Receive appropriate care and treatment for your medically certified health condition.

- File a claim for STD benefits within 90 days following your date of disability. Date of disability is generally defined as the first day that you are medically unable to work due to your condition. Certification must be received to validate that you meet the definition of disability as defined by the plan as of this date. For more information, see "5. Timely action required" on page 10-7.
- Receive approval of STD benefits in accordance with the provisions of the STD Plan.

Even though you may qualify for disability income from other sources such as State Disability Insurance, you must satisfy all of the criteria of the STD Plan before you will qualify for STD benefits under the STD Plan.

Medically certified health condition definition

For purposes of the STD Plan, a medically certified health condition is generally defined as a disabling injury or illness that:

- Is documented by clinical evidence as provided and certified by an approved care provider. Clinical evidence may include medical records, medical test results, physical therapy notes, mental health records, and prescription records.
- Prevents you from performing the essential functions, duties, and regular schedule of your position as of the last day worked for longer than the STD waiting period.

Note: Not all conditions are covered; refer to the "Exclusions" section on page 10-14 for more information.

Pregnancy

Your date of disability will be considered your date of delivery (or the day after your delivery if you worked on the day you delivered). After you deliver your baby, you may be eligible for six or eight weeks of STD benefits which will include your one week for the STD waiting period if you have not already satisfied it prior to your date of delivery (see the "STD waiting period" section on page 10-7 for more information). You may also be eligible for Parental Leave, which would allow you to receive income replacement beginning on the date of the delivery (parental leave is not part of this STD Plan). See the "How the STD Plan coordinates with Wells Fargo's Parental Leave" section on page 10-12 for more information.

If you experience complications during or after your pregnancy that result in an inability to work, you may be eligible for STD benefits before or after delivery based on the medical information provided to Lincoln. Disabling medical complications related to pregnancy are treated the same as any other disabling injury or illness under the STD Plan. For example, fatigue associated with pregnancy may not qualify as a medically certified health condition under the STD Plan unless your approved care provider documents the clinical evidence that the fatigue prevents you from performing the essential duties of your regular job. For more information, see the "Qualifying for STD benefits" section starting on page 10-7.

Valid medical information

The medical information you provide in support of your claim must be accurate. If the information is not accurate or the signature of the health care provider is not valid as determined by Lincoln, your claim for STD benefits will be denied or discontinued, you will be disqualified from participating in the STD Plan, and you may be subject to further disciplinary action, including termination of employment.

Approved care provider definition

"Approved care provider" means a person who is legally licensed to practice medicine and is not you or related to you. A licensed medical practitioner will be considered an approved care provider if:

- Applicable state law requires that such practitioners be recognized for the purposes of certification of disability.
- The care and treatment provided by the practitioner are within the scope of his or her license.

An approved care provider includes a licensed Ph.D. psychologist or other licensed mental health practitioner.

Appropriate care and treatment definition

"Appropriate care and treatment" means medical care and treatment that meets all of the following criteria:

- It is received from an approved care provider whose training and experience are suitable for treating your medically certified health condition.
- It is necessary to meet your health needs and is of demonstrable medical value.
- It is consistent in type, frequency, and duration of treatment with relevant guidelines of national medical, research, and health coverage organizations.
- It is consistent with the diagnosis of your condition.
- Its purpose is to maximize your medical improvement.

Proof of your disability

It is your responsibility to ensure that Lincoln receives requested medical proof of your disability, which may include medical records, test results, and hospitalization records, within the designated time frame. If Lincoln has not received the requested medical documentation and valid medical proof within 30 days from the later of the date your claim was filed or your date of disability, your request for STD benefits will be denied. A claim for STD benefits must be filed no later than 90 days following your date of disability (see the "date of disability" definition in the "Qualifying for STD benefits" on page 10-7).

You can file a claim for STD benefits beyond 90 days following your date of disability if you can show both of the following:

- It was not reasonably possible to give timely written proof of your claim for Short-Term Disability benefits. Such proof must be provided as soon as reasonably possible but in no event,

except in the absence of your legal capacity, later than one year from the time proof is otherwise required.

- Medical information supporting your claim for STD benefits satisfactory to Lincoln was provided as soon as was reasonably possible.

Benefits determination

The determination of a claim for STD benefits is based on one or more of the following:

- Medical information provided by your approved care provider or providers
- Professional opinions of other care providers as designated by Lincoln
- Other criteria as specified in this Chapter

You will receive written notification of the status of your claim for STD benefits within 45 days of Lincoln's receipt of your claim for STD benefits. You will receive only one determination (approval or denial) that applies to both the STD Plan and the STD Top-Up Plan.

Approvals

Approval of a claim for STD benefits is based on one or more of the following:

- Medical information provided by your approved care provider or providers
- Professional opinions of other care providers as designated by Lincoln
- Other criteria as specified in this Chapter

You will receive written notification of the status of your claim for STD benefits within 45 days of Lincoln's receipt of your claim for STD benefits. If your claim for STD benefits is approved, the letter will state the expected duration of your STD benefits, when updated medical information is due, or when benefits will stop. Approvals are retroactive to the first day you are medically certified to miss work after the STD waiting period. For more information, see the "Claims and appeals" section starting on page 10-14.

Denials

If Lincoln denies your claim for STD benefits in whole or in part, the notification of the claims decision will be provided to you and will state the reasons why your claim was denied and reference the specific STD Plan provision or provisions on which the denial is based. You have the right to appeal this determination. For more information, see the "Claims and appeals" section starting on page 10-14.

After a claim for STD benefits has been denied, if you continue to remain out of work due to your medically certified health condition (the health condition that was the basis for your denied claim) or for any other reason, you are not eligible to file a subsequent claim for STD benefits for this same health condition (excluding pregnancy) while you remain out of work even if you are on an approved leave of absence. (However, you have the right to appeal the denied claim; see the "Filing an appeal" section starting on page 10-15.) Lincoln will notify you of the requirements for maintaining an approved leave of absence with Wells Fargo if your claim for STD benefits was denied and you continue to remain out of work due to your medically certified health condition. Failure to comply with those requirements may result in corrective action up to and including termination of your employment.

Disability case management

Lincoln will assign a disability case manager to provide case management services, to monitor your continuing eligibility for STD benefits, and to facilitate your timely return to work. Your Lincoln Case Manager will monitor the payment of your STD benefits to ensure that your benefit is being processed correctly. It is your responsibility to keep Lincoln and your supervisor informed with updates about your leave status.

Confidentiality of medical information

Medical information about your diagnosis, treatment plan, and care provider will be kept confidential by Lincoln, unless your file is released to the plan administrator or its designee in connection with an appeal. Lincoln may release medical information to a third-party vendor or to your treating providers as it pertains to your claim for disability benefits. Such information will not be disclosed to your supervisor without your consent or made part of your personnel file.

With your written consent, information may be shared with Wells Fargo as it pertains to administration of your leave (Leave Disability Management), as it pertains to your return to work (Accommodations Management), or as it pertains to mental health referrals (Employee Assistance Consulting). Information about your dates of leave, eligibility for STD benefits, return to work dates, work restrictions, requested accommodation, or any combination thereof may be provided to your supervisor or Human Resources consultant and may be noted in your personnel file.

Medical evaluations and treatment plans

Your approved care provider should establish a detailed treatment plan to assist you in your recovery and continue to provide proof of your disability to Lincoln. Before you can return to work, Lincoln and your supervisor must receive a signed confirmation of your release to return to work from your approved care provider. Your release must explain any requested accommodations or work restrictions.

Independent medical examinations

Lincoln may request another care provider to examine you. This is called an "independent medical examination." The purpose of this exam is to obtain additional information about your condition and treatment plan for the purpose of determining your eligibility for STD benefits. Lincoln chooses the care provider who examines you and pays for the examination. In some cases, more than one independent medical examination may be required. Your refusal to attend or cooperate with the independent medical examination may result in a denial or discontinuation of STD benefits.

In some cases, STD benefits may be stopped at the time the independent medical examination is ordered until the results of the independent medical examination are received and a decision can be made about your eligibility for STD benefits. After your eligibility for STD benefits is approved, STD benefits will be reinstated retroactive to the date benefits stopped.

Additional evaluations

Lincoln may also request that you receive additional evaluations, which may include rehabilitation, functional, psychological, or vocational evaluations. These evaluations are also used to determine your health status and ability to work. You are required to participate in these evaluations to receive or to continue receiving STD benefits. These evaluations will be provided at no cost to you.

On-site medical case management

Lincoln may contract with an on-site medical case manager to assist you and your Lincoln disability case manager to facilitate your timely return to work. The on-site medical case manager may accompany you to medical appointments, review and coordinate care and treatment, visit your home and workplace, and communicate with your care providers, supervisor, Human Resources consultants, and your Lincoln disability case manager. You are required to cooperate with on-site medical case management to continue receiving STD benefits.

Recurrent condition

If your medically certified health condition starts again within 30 calendar days after you have been released to return to work, your condition may be considered a recurrent condition. A recurrent condition is due to the same cause or complication resulting from the initial medically certified health condition. It will be treated as a continuation of your initial medically certified health condition, and you will not have to satisfy a new STD waiting period. The maximum amount of time you may receive STD benefits for the same condition is 26 weeks, which includes the STD waiting period.

If your medically certified health condition starts again 30 calendar days or more after you have been released to return to work on a full-time basis, it will be treated as a new condition under the STD Plan. If that is the case, you will be required to satisfy a new waiting period.

Your covered pay for purposes of determining your STD benefit will be based on your covered pay at the time the condition originally started, versus when the condition starts again, unless you are required to file a new claim (see the "Covered pay" section on page 10-11).

If you are disabled and working (reduced work schedule)

A reduced work schedule is an accommodation provided to you by your supervisor, Wells Fargo Accommodations Management, or both if you have proof of a disability that prevents you from working 100% of your predisability standard hours as documented by your health care provider. All accommodations must be reviewed and approved by your supervisor, Wells Fargo Accommodations Management, or both.

STD benefits may be paid in combination with the earnings you receive while on a reduced work schedule based on the applicable percentages and time periods described in the "STD benefits schedule" on page 10-11. As a result, in addition to your reduced work schedule earnings, you may receive STD benefits up to your eligible STD benefit amount reduced by other sources of income (see the "Deductible sources of income" section on page 10-12). To be eligible to receive STD benefits on a reduced work schedule, you must satisfy the waiting period and be earning between 20% and 80% of your covered pay (see the "Covered pay" section on page 10-11).

Reduced work schedule STD pay examples

- Example 1 for employees who have satisfied the STD waiting period and who are eligible for an STD benefit of 65% of their covered pay* (and are not receiving any sources of income other than the reduced work schedule earnings)
  - If your normal biweekly pay amount is $1,000 as an employee working 40 hours per week
    - At a 65%* STD benefit level, your maximum STD benefit would be $650 biweekly
  - If, on the reduced work schedule, you work 20 hours per week and earn $500 biweekly (for your hours worked)
    - The remaining eligible STD benefit would be $150 biweekly (the $650 STD maximum benefit minus the $500 biweekly pay for hours worked)

* Your eligible STD benefit amount is based on the "STD benefits schedule" noted on page 10-11.

- Example 2 for employees who have satisfied the STD waiting period and who are eligible for an STD benefit of 100% of their covered pay* (and are not receiving any sources of income other than the reduced work schedule earnings)
  - If your normal biweekly pay amount is $1,000 as an employee working 40 hours per week
    - At a 100%* STD benefit level, your maximum STD benefit would be $1,000 biweekly
  - If, on the reduced work schedule, you work 20 hours per week and earn $500 biweekly (for your hours worked)
    - The remaining eligible STD benefit would be $500 biweekly (the $1,000 STD maximum benefit minus the $500 biweekly pay for hours worked)

* Your eligible STD benefit amount is based on the "STD benefits schedule" noted on page 10-11.

STD Plan benefits

Generally, STD benefits replace either 65% or 100% of your covered pay, referred to as 'salary' in the Benefits section of Workday, for up to 25 weeks, after completion of the STD waiting period, based on your completed years of service, as shown in the table below. For information on covered pay, see the "Covered pay" section on page 10-11.

Note: Your STD waiting period of the first seven consecutive days counts toward the 26 weeks.

STD benefits schedule

Completed years of service	Weeks at 100% of covered pay*	Weeks at 65% of covered pay*
Less than 1 year – 3 years	4 weeks	21 weeks
4 – 6 years	7 weeks	18 weeks
7 – 9 years	13 weeks	12 weeks
10 or more years	25 weeks	None

* After completion of the STD waiting period (see the "STD waiting period" section on page 10-7 for more information).

Completed years of service

For STD benefits, your completed years of service are measured from your Continuous Service Date as explained in Workday and Payroll System. You are credited with one year of service after each full 12-month period of employment is completed.

Covered pay

If you meet the criteria for STD benefits, your benefits are based on covered pay in effect on the day before the initial date of your disability. Your covered pay is determined by the job classification code (job class code) for your position in Workday. To view your STD covered pay, log into Workday, go to View Profile, then choose Actions, then choose Benefits, and View Benefits Annual Rate to see your STD Covered Pay.

Job class code 2

Most positions within Wells Fargo are job class code 2. For job class code 2 positions, covered pay is defined by your annual base salary. Annual base salary is your hourly rate of pay (including geographical differentials, if applicable) multiplied by the number of standard hours indicated in Workday and takes into account the number of working days each calendar year. The amount is multiplied by the number of weeks in a calendar year to determine your annual base salary. Base salary may be expressed as an annual, monthly, or hourly rate. Base salary includes amounts designated as before-tax contributions you make to Wells Fargo's sponsored benefit plans, but it does not include overtime pay, shift differentials, language differentials, incentives, bonuses, commissions, or perquisites such as parking or auto allowances or commute subsidies.

Covered pay considered for purposes of determining disability benefits under the STD Plan will be limited to the annual amount set forth in Section 505(b)(7) of the Internal Revenue Code and is subject to change by the federal government at its discretion. If your covered pay for benefit purposes exceeds that amount, the amount exceeding the limit will be considered covered pay under the STD Top-Up Plan. If benefit payments are due from both the STD Plan and STD Top-Up Plan, the payments will be consolidated into a single check each time payments are due.

Job class codes 1 and 5

Variable Incentive Compensation positions

Variable Incentive Compensation (VIC) applies to jobs with a pay structure designed to deliver 40% or more of the expected total cash through incentives that are paid primarily on a monthly or quarterly basis. Assignment of jobs to VIC requires approval of Wells Fargo Rewards and Performance Management. For VIC employees (positions assigned job class code 5 in Workday), covered pay is your benefits base as indicated on that system based on the most recent quarterly earnings calculation. Generally, quarterly calculations are completed sometime in the first several days of each quarter. The amount of covered pay is updated on the day of the calculation. Benefits base is calculated quarterly by annualizing earnings based on salary and incentives or commissions paid in the last 12 months, divided by the number of months with earnings greater than $0, up to a maximum amount set forth in Section 505(b)(7) of the Internal Revenue Code and is subject to change by the federal government at its discretion. Benefits base does not include some forms of compensation such as overtime pay, shift differentials, hiring and retention bonuses, noncash awards, and prerequisites (such as parking or auto allowance or commute subsidies).

Wells Fargo Mortgage Consultant Participant positions

For Mortgage Consultant Participant employees (positions assigned a job class code 1 in Workday), covered pay is your benefits base as indicated on that system up to a maximum amount set forth in Section 505(b)(7) of the Internal Revenue Code and is subject to change by the federal government at its discretion.

When employees in job class code 1 qualify for STD, the regular or guaranteed commission and the credit draw commission

continue during the seven-day waiting period, unless you have PTO available. The draw is then discontinued at the start of the Medical Leave. The draw resumes on the first day the employee returns to work (including on a flex-time basis or reduced work schedule). The excess (if any) net commission credit is given to the employee. In no case will the employee earn less than the calculated STD benefit each month while on leave.

STD benefit amount

STD benefits are generally based on your covered pay, referred to as "salary" in the Benefits section on Workday, in effect on the day before the initial date of your disability, and on your completed years of service on the first day of your disability, as shown in the "STD benefits schedule" on page 10-11.

How the STD Plan coordinates with Wells Fargo's Parental Leave

This section is for informational purposes only and is not part of the STD Plan or any other ERISA benefit sponsored by Wells Fargo & Company.

Parental Leave supplements the benefits you may be eligible for under the STD Plan if the condition for which you are requesting STD Plan benefits is due to the birth of your child and your claim is approved.

- If you are eligible for 100% benefits under this STD Plan (offset by deductible sources of income as noted below), generally you would not receive income replacement via Parental Leave for the time period that the STD Plan benefit runs concurrent to the Parental Leave.
- If you are eligible for 65% benefits under this STD Plan (offset by deductible sources of income as noted below), your concurrent income replacement under Parental Leave will be reduced accordingly, and you will only receive 35% of your income replacement under Parental Leave for the time period that the STD Plan benefit runs concurrent to Parental Leave.

You will never receive more than 100% of your predisability covered pay. For more information about Parental Leave, refer to Service Now or call Lincoln at 1-866-213-2937.

Deductible sources of income

You will never receive more than 100% of your predisability covered pay, referred to as "salary" in the Benefits section of Workday. Your STD benefit automatically will be reduced by the amount of income you receive (or are eligible to receive) from other sources, including but not limited to:

- Statutory benefits, such as state-mandated disability benefits.
- Workers' Compensation benefits attributed to lost income, including a settlement awarded to you.
- Automobile and other accident wage replacement income.
- Income while you are working under an approved reduced work schedule.
- Any income received for disability under a government compulsory benefit or program that provides for loss of time from your job due to your disability, whether such payment is made directly by the plan or program or through a third party (including but not limited to Social Security disability, retirement, and dependent's benefits, but excluding survivor benefits).
- Third-party recovery for loss of income by judgment, settlement, or otherwise, including recovery amounts you may receive from future earnings as permitted by state law.

If you work in a state or commonwealth with a mandatory disability program (currently California, Hawaii, Massachusetts, New Jersey, New York, Puerto Rico, Rhode Island, Washington State, and Washington D.C.), it is your responsibility to apply for statutory benefits for most states. Lincoln will file with Hawaii, New Jersey, and New York on your behalf.

If your employment ends before the date you become disabled, you will not be eligible for STD coverage.

Payment of STD benefits

Once the plan administrator receives notification from Lincoln that your STD claim meets the criteria for approval, all STD benefits will be paid through the Wells Fargo regular biweekly payroll system. Your regular benefit deductions will continue to be taken from your STD benefits in accordance with the provisions of the other Wells Fargo plans in which you participate. In some instances, your health benefit deductions may not be included in your disability check. In these cases, you may be billed later. You should review each payment to ensure that the appropriate deductions have been taken for your health benefits.

Recovery of overpayment

If you receive excess STD benefits because you receive income from one of these deductible sources described in the "Deductible sources of income" section starting on this page or due to a miscalculation of your benefit amount, the STD Plan or the plan administrator or its designee reserves the right to seek full reimbursement of the amounts overpaid, including but not limited to offsetting any future STD benefits by the amount overpaid.

Right of recovery

When your injury or sickness appears to be someone else's fault, benefits otherwise payable under the STD Plan for loss of time as a result of that injury or sickness will not be paid unless you or your legal representative agree to the following:

- To repay the STD Plan for such benefits to the extent they are for losses for which compensation is paid to you by or on behalf of the person at fault.
- To allow the STD Plan to place a lien on such compensation and to hold such compensation in trust for the STD Plan.
- To execute and give to the plan any instruments needed to secure the rights under the first two conditions, above.

Further, when the STD Plan has paid benefits to you or on your behalf, the STD Plan may be subrogated to all rights of recovery that you have against the person at fault. These subrogation rights will extend only to recovery of the amount the STD Plan has paid. You must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the STD Plan.

You must also agree not to take any action that is inconsistent with the STD Plan's right to reimbursement. Reimbursement will be made regardless of whether you are fully compensated, or "made whole," by the settlement, verdict, judgment, award, or insurance proceeds and regardless of whether costs are allocated to "loss of income." The STD Plan will not be responsible for bearing the cost of any legal fees you incur as a result of any action you take against the third party.

If you refuse to fully reimburse the STD Plan after receipt of a settlement, verdict, judgment, award, or insurance proceeds, the STD Plan may not pay for any future benefits. The STD Plan may seek legal action against you to recover paid benefits related to your injury or condition. In addition, the STD Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent benefits are paid by the STD Plan.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator, in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Taxes on STD benefits

STD benefits are taxable income. Wells Fargo withholds federal, state, local, and Social Security taxes from your STD benefits.

When STD benefits end

Generally, the maximum amount of time you may receive STD benefits for the same condition is 25 weeks after completion of the STD waiting period. STD benefits may end sooner if you are unwilling or fail to do any one of the following:

- Provide medical evidence in a timely manner.
- Provide requested medical records.
- Receive continuing care and treatment from an approved care provider, appropriate to your condition, during the time period for which STD benefits are requested.
- Participate in additional medical and other evaluations requested by Lincoln. For more information, see the "Medical evaluations and treatment plans" section on page 10-9.
- Cooperate with on-site medical case management.
- Follow the prescribed treatment plan.
- Follow approved work restrictions or accommodations.
- Return to work when medically certified to do so.
- Accept the same or equivalent offer of employment within your medical restrictions.
- Begin working for wage or profit if not under an approved reduced work schedule.
- The date your weekly earnings exceed 80% of your predisability covered pay.
- The day you have received the maximum amount of STD benefits, as shown in the "STD benefits schedule" section on page 10-11, for the same or related health condition that gave rise to your STD claim.

In addition, your STD benefits may end if your employment is terminated for any reason. **Note:** If you are notified of a qualifying event under the Wells Fargo & Company Severance Plan and receiving STD benefits during the notice period or prior to your severance eligibility period, STD benefits will be paid until benefits end (up to 25 weeks).

Survivor benefit

If you die while receiving STD benefits, the STD Plan will pay your beneficiary a lump sum in an amount equal to 10 times your predisability biweekly covered pay, referred to as "salary" in the Benefits section of Workday, based on your covered pay in effect on the day before the initial date of your disability. For example, if you are an employee who has a covered pay amount of $35,000 per year, you would calculate $35,000 per year divided by 26 weeks to get a $1,346.16 biweekly rate. To calculate the survivor benefit, take this amount and multiply it by 10 to get $13,461.60. In this example, $13,461.60 would be paid to your designated beneficiary at the time of your death. The survivor benefit will be reduced by any overpayment of STD benefits that may exist. Taxes will not be withheld from your survivor benefit. Your estate or the benefit recipient may, however, be required to pay additional taxes to the state or federal government. Consult a tax advisor for tax information related to your survivor benefit.

You will be asked to name one or more beneficiaries when you enroll in benefits, using the online Beneficiary Designation Tool in Workday. If you need to change your beneficiaries during the year, you may do so at any time by going to the Beneficiary Designation Tool in Workday.

If a beneficiary is not designated, the beneficiary dies before you, or at the same time as you, and no contingent beneficiary was named, or the contingent beneficiary has also died before you, the death benefit is paid to your survivors in the following order:

1. Your surviving spouse or domestic partner[1]
2. Equally among your surviving biological and adopted children[2]
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

1. See the "Definitions relating to marital status" section on page 10-14 for more information.
2. Except that if any of the participant's children predecease him or her but leave descendants surviving, such descendants shall take by right of representation the share their parent would have taken, if living.

To qualify for a survivor benefit, the following conditions must be met:

- You completed the STD waiting period.
- You were eligible to receive STD benefits at the time of your death.
- You were not working a reduced work schedule due to your disability.
- Proof of your death is provided to Wells Fargo.

If your beneficiary disagrees with the determination on your eligibility or the amount of the survivor benefit, your beneficiary has the right to request and obtain a copy of this SPD.

Upon your beneficiary's written request, the plan administrator will provide, free of charge, copies of documents, records, and other information relevant to your survivor benefit.

Definitions relating to marital status

For payment of a benefit if there are no surviving or designated beneficiaries, the following terms have the meanings assigned to them below:

- "Spouse" means the person to whom you are legally married on your date of death under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, or the person who was your current common-law spouse on your date of death in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages.
- "Domestic partner" means a person of the same or opposite gender who is not your spouse as defined above, that meets at least one of the following criteria on your date of death:
  - You and the person are joined in a civil union (or other similar formal relationship) on your date of death that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the union was created but is not denominated or recognized as a marriage under the laws of that state or country.
  - You and the person share a domestic partnership (or other similar formal relationship) on your date of death that is registered by a city, county, state, or country but is not denominated or recognized as a marriage under the laws of that city, county, state, or country.
  - You and the person both meet all of the following requirements:
    i. You shared a single, intimate, committed relationship of mutual caring as of your date of death and intended to remain in the relationship indefinitely.
    ii. You resided together in the same residence and lived in a spouse-like relationship prior to your date of death.
    iii. You are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which you reside.
    iv. Neither of you was married to another person under either federal, state, or common law, and neither is a member of another domestic partnership.
    v. You were both mentally competent to consent or contract.
    vi. You were both at least 18 years old.
    vii. You were financially interdependent, jointly responsible for each other's basic living expenses, and if asked, your partner is able to provide documentation for three of the following being in effect as of your date of death:
      A. Joint ownership of real property or a common leasehold interest in real property
      B. Common ownership of an automobile
      C. Joint bank or credit accounts
      D. A will that designates the other as primary beneficiary
      E. A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other
      F. Designation of one partner as holding power of attorney for health care decisions for the other

Exclusions

Not all conditions are covered by the STD Plan. STD benefits will not be paid for any condition that is caused by or results from:

- Your commission or attempted commission of any criminal act, including but not limited to an assault, battery, felony, or any combination thereof
- Injuries you sustain or illness contracted while you are performing services for, or receiving compensation from, the military
- A cosmetic surgery or elective procedure, unless the surgery or procedure is:
  - Performed in connection with, or as a result of, a covered injury, accident, or illness in which the surgery or procedure is required due to reconstruction or medical necessity
  - Gender reassignment-related services (pre- and post-surgery)
  - Performed in connection with organ donation

Claims and appeals

Filing a claim

For information on how to file a claim for STD benefits, see the "How to file a claim for STD benefits" section starting on page 10-6. It is important to note that there is a claims filing deadline. You may report your claim for disability benefits up to 30 days in advance of the date your leave is to begin (for example, if you have a planned surgery), and you must file your claim for STD benefits no later than 90 days following your date of disability (see reference to the date of disability definition in the "Qualifying for STD benefits" section on page 10-7).

Claim determinations, determination extension, and requests for additional information

After you submit a claim for STD benefits, Lincoln will review your claim and notify you of its decision to approve or deny your claim. Such notification will be mailed to you within a reasonable period, not to exceed 45 days from the date you submitted your claim, except for situations requiring an extension of time because of matters beyond the control of the STD Plan. In such cases, Lincoln may have up to two additional extensions of 30 days each to provide you such notification.

If Lincoln needs an extension, it will notify you before the expiration of the initial 45-day period (or before the expiration of the first 30-day extension period if a second 30-day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of Lincoln's notice requesting additional information and an extension until Lincoln receives the requested information does not count toward the time period that Lincoln is allowed to notify you of its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting additional information from Lincoln.

Content of the claim determination notice

As noted in the "Claim determinations, determination extension, and requests for additional information" section on page 10-14, you will receive notice of the claim determination. An adverse benefit determination is a denial of your claim in whole or in part. Adverse benefit determinations will contain a complete discussion on why the claim was denied. If you receive an adverse benefit determination, the notice will provide the following information:

- The specific reason or reasons for the adverse determination.
- Reference to the specific STD plan provisions on which the determination is based.
- If the claim is denied because Lincoln did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.
- If an internal rule, protocol, guideline, or other criterion was relied upon to make the determination, the decision will state the internal rule, protocol, guideline, or other criterion or indicate that a copy of such rule, protocol, guideline, or other criterion will be provided free of charge to you upon request.
- If the adverse determination is based on medical necessity, experimental treatment, or similar exclusion or limit, you will receive an explanation of scientific or clinical judgment for the determination, applying the terms of the STD Plan to the claimant's medical circumstances or a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request.
- An explanation of the basis for disagreeing (or not) with any of the following information:
  - The views presented by the claimant of treating health care professionals or vocational professionals who evaluated you
  - The views of the medical or vocational experts whose advice was obtained in connection with the decision, whether or not relied upon
  - A Social Security disability benefit determination presented by you
- A description of the plan's claim appeal review procedures (including the time limits applicable to such procedures) and a statement regarding your right to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended (ERISA) Section 502(a) following an adverse benefit determination on appeal.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
- Any additional information required under applicable law.

For additional information on filing an appeal under the STD Plan, see the "Filing an appeal" section starting on this page.

Filing an appeal

If Lincoln denies your STD claim in whole or in part, you believe you should be entitled to a different amount of STD benefits, or you disagree with any determination that has been made reflecting your benefits under the STD Plan, you (or your authorized representative) may appeal the decision. You (or your authorized representative) must file your appeal in writing within 180 days of the date you receive Lincoln's written adverse benefit determination of your claim, regardless of any discussions or consultations about the claim. The STD Plan has one level of appeal, which is reviewed by Lincoln. You or your duly authorized representative must sign your appeal request. It should be sent to Lincoln by U.S. mail to the following address:

Lincoln Financial Group
Disability Claims
PO Box 2578
Omaha, NE 68172-9688

The address for filing an appeal is also noted in Lincoln's adverse benefit determination letter.

Your appeal must be submitted in writing to Lincoln and must include at least the following information:

- Your name
- Your claim number
- Name of plan (that is, the Wells Fargo & Company STD Plan)
- Reference to the initial determination
- An explanation of why you are appealing the determination

As part of your appeal, you may submit any additional written comments, documents (including additional medical information), records, or other information relating to your appeal that supports your request for benefits. Upon your written request, Lincoln will provide you free of charge with copies of documents, records, and other information relevant to your initial claim. A request for this information does not, however, extend the time frame you have to file your appeal.

The appeal process is your opportunity to present documentation and evidence to show that your claim for benefits is covered and payable under the STD Plan. However, the review process does not permit you, your beneficiary, or your authorized representative to appear in person before, or meet with, anyone from Lincoln. It is your responsibility to submit any information or documentation that you wish to have considered for the appeal review within the required time frame. Please note that Lincoln does not reimburse fees that may be associated with filing the appeal or with your obtaining information you wish to have reviewed in support of your appeal.

After Lincoln receives your written, timely filed appeal request, it will conduct a full and fair review of your appeal. The reviewer will look at the claim anew, and no deference will be given to the prior denial. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination of your claim.

In addition, the person who will review your appeal will not be the same person who reviewed your claim or a subordinate of the person who made the initial decision to deny your claim (in whole or in part). If the initial denial is based in whole or in part on a medical judgment, the reviewer will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

Note: It is very important that you submit all of the information you want reviewed when your appeal is filed. The date the appeal is filed is the date it is received by Lincoln. Lincoln must make the appeal determination within the time frame stated below based on the date that you file your appeal regardless of whether you indicate more information to be forthcoming.

Lincoln will provide you, free of charge, with copies of any new or additional evidence or rationale considered, relied upon, or generated in connection with the claim appeal review as soon as possible and sufficiently in advance of the date on which the notice of final benefit determinant is required to be provided to you (to give you a reasonable opportunity to respond prior to that date). After you receive the information, if you feel there is a need, you may submit additional information to Lincoln for final consideration in the appeal review process (such information must be submitted before the final determination is due). Lincoln must consider any response from you as part of its decision making process, provided it is submitted before the final determination is due.

Appeal determination

After you file your appeal for disability benefits with Lincoln, it (or its designated representative) will review your appeal and notify you of its decision to approve or deny your appeal. This notification will be mailed to you within a reasonable period, but no later than 45 days after Lincoln's receipt of your written request for appeal review, except for situations requiring an extension of time because of matters beyond the control of the STD Plan. If an extension is required, Lincoln may have up to an additional 45 days to provide you with notification of the final decision. If such an extension is needed, Lincoln will notify you before the expiration of the initial 45-day period, state the reason or reasons why the extension is needed, and state when it will make its determination. You will have 45 days to provide any requested information from the date you receive the notice from Lincoln.

If Lincoln denies your claim on appeal in whole or in part (an adverse benefit determination), it will send you a final written decision. The notification of the decision will provide the following information:

- The specific reason or reasons why your appeal was denied.
- Reference to the specific STD Plan provision or provisions on which the denial was based.
- If the appeal was denied because sufficient information was not provided, a description of the additional information needed and an explanation as to why it was needed.
- An explanation of the basis for disagreeing (or not) with any of the following information:
  - The views presented by the claimant of treating health care professionals or vocational professionals who evaluated you
  - The views of the medical or vocational experts whose advice was obtained in connection with the decision, whether or not relied upon
  - A Social Security disability benefit determination presented by you
- If an internal rule, protocol, guideline, or other criterion was relied upon to make the determination, the decision will state the internal rule, protocol, guideline, or other criterion or indicate that a copy of such rule, protocol, guideline, or other criterion will be provided free of charge to you upon request.
- If the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of scientific or clinical judgment for the determination, applying the terms of the STD Plan to the claimant's medical circumstances or a statement that such explanation of the scientific or clinical judgment will be provided free of charge upon request.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
- If applicable, a description of the plan's additional claim appeal review procedures (including the time limits applicable to such procedures).
- A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.
- A description of any applicable contractual limitations period and its expiration.
- Any additional information required under applicable law.

If you wish to receive copies of documents, records, and other information relevant to the final appeal decision, send Lincoln your written request for documents, records, and other information.

Legal action

With limited exceptions for violations of claim procedure regulations, no legal action can be filed against the Plan until the STD Plan's claims and appeals procedures have been exhausted (refer to the "Claims and appeals" section starting on page 10-14 for more information). Any suit for benefits must be brought within one year from the date the final appeal determination was issued by Lincoln.

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Chapter 11: Short-Term Disability Top-Up Plan

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Contacts

To file a claim or for information about your existing claim	Claims Administrator Lincoln Financial Group (Lincoln) 1-866-213-2937 mylincolnportal.com (company code: wells)
To fax documentation about your claim	Lincoln 1-866-214-7839
Information about the Short-Term Top-Up Disability Plan	HR Services & Support site Lincoln 1-866-213-2937 wellsfargo@lfg.com

The information in this booklet — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Important Notifications and Disclosures," and "Appendix D: Leaves of Absence and Your Benefits" — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Short-Term Disability Top-Up Plan (the STD Top-Up Plan) that covers eligible Wells Fargo employees.

The basics

General information

Wells Fargo provides short-term disability benefits through two different plans: the Wells Fargo & Company Short-Term Disability Plan (the "STD Plan") and the Wells Fargo & Company Short-Term Disability Top-Up Plan (the "STD Top-Up Plan"). Most benefits are paid through the STD Plan, but some employees in job class code 2 whose annual covered pay, referred to as "salary" in the Benefits section of Workday, exceeds the annual amount set forth in Section 505(b)(7) of the Internal Revenue Code (the "compensation limit") may receive benefits from both plans. The compensation limit is subject to change by the federal government at its discretion. Payment of benefits from both plans is necessary for technical reasons, but you will receive only one check that will include all your disability benefits. This SPD describes the provisions of the STD Top-Up Plan. The provisions of the STD Plan are not part of this SPD and the provisions of this SPD are not part of the STD Plan.

The STD Top-Up Plan provides short-term disability coverage on a self-insured basis and is classified as a "welfare benefit plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA). The three-digit plan code is 523 and the service provider is the claims administrator (see additional information about the claims administrator on this page).

The STD Top-Up Plan provides you with short-term disability benefits if you have a medically certified health condition and are unable to perform some or all of your job duties for more than seven consecutive calendar days (the "STD waiting period"). (Please review the "Medically certified health condition definition" section on page 11-8.) As it pertains to the waiting period, if you are working a partial schedule as a result of a medically certified health condition, you are not eligible to receive STD benefits until you have been out of work completely for more than seven consecutive calendar days.

Generally, STD benefits replace either 65% or 100% of your covered pay per week, depending on your completed years of service, for up to 25 weeks following your completion of the seven consecutive day STD waiting period. (Please review the "STD benefits schedule" on page 11-11.) STD benefits coordinate with other sources of income you receive so that your STD benefit combined with other sources of income is never more than 100% of your predisability covered pay.

If your claim is approved for STD benefits, the benefits attributed to the amount of your covered pay that exceeds the compensation limit will be paid by this STD Top-Up Plan. Benefits under the STD Top-Up Plan are paid from Wells Fargo general assets.

For an approved STD claim, each pay period you will receive one STD benefit payment that will include all your disability benefits, that is those paid from the STD Plan and the STD Top-Up Plan combined.

Claims administrator

The STD Top-Up Plan is self-insured, and Lincoln Financial Group (Lincoln) is the claims administrator providing administrative claims services. Lincoln has full discretionary authority to administer and interpret the STD Top-Up Plan. Lincoln can be reached at 1-866-213-2937.

Who's eligible

Eligible employees

You are eligible for the STD Top-Up Plan if you meet all of the following:

- You are a regular or fixed term Wells Fargo employee as described in "Chapter 1: Eligibility, Enrollment, and More"
- Your position is classified as "Job class code 2" as described on page 11-11
- Your "Covered pay" as described on page 11-11 exceeds the compensation limit

Ineligible employees

You are not eligible to participate in the STD Top-Up Plan if your covered pay, referred to as "salary" in the Benefits section of Workday, is less than the compensation limit or if you are:

- Classified as an intern or flexible employee.
- In a position classified as job class code 1 or 5
- An employee of an affiliate not participating in the STD Top-Up Plan.
- An employee who is classified as an international employee.
- A person whom Wells Fargo classifies as an independent contractor or any other status by which you are not treated as a common-law employee of Wells Fargo for purposes of withholding taxes, regardless of your actual status. (This applies to all periods of such service of an individual who is subsequently reclassified as an employee, whether the reclassification is retroactive or prospective.)
- A regular or fixed term employee who is on certain types of leaves of absence (see "Appendix D: Leaves of Absence and Your Benefits")

Cost

Wells Fargo pays the entire cost of your coverage under the STD Top-Up Plan.

How to enroll

You are automatically enrolled in the STD Top-Up Plan if you meet the eligibility requirements described in the "Who's eligible" section on page 11-3.

When coverage begins

New hire or newly eligible

For eligible employees, STD Top-Up Plan coverage begins the first of the month following one full calendar month of service in a regular or fixed term position, subject to the requirement that you be actively at work on your first day of coverage. If you are not actively at work the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a regular or fixed term position. For more information, see the "Actively at work definition" section on this page.

If you were previously employed by a company that was acquired by or merged with Wells Fargo, certain transition rules may apply to your participation in the STD Top-Up Plan when you first become an employee as a result of the acquisition or merger.

Rehired employees

If you are rehired within the six-month period following your termination date and meet the eligibility requirements for the STD Top-Up Plan, your STD Top-Up Plan coverage begins on your rehire date provided that you were covered by the STD Top-Up Plan at the time of your termination. If you had not yet completed one full calendar month of service at the time of your termination, your STD Top-Up Plan coverage will begin on the first of the month following one full calendar month of service after your rehire, subject to the requirement that you be actively at work on your first day of coverage as described below.

If you are rehired into a regular or fixed term position after the six-month period following your termination date and meet the eligibility requirements for the STD Top-Up Plan, your STD Top-Up Plan coverage will begin on the first of the month following one full calendar month of service after your rehire, subject to the requirement that you be actively at work on your first day of coverage as described below.

In either case, if you are not actively at work the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a regular or fixed term position. For more information, see the "Actively at work definition" section on this page.

If you are a Wells Fargo retiree who was rehired on or after January 1, 2011, in a regular or fixed term position, your coverage begins on your first day of active employment in a regular or fixed term position.

Employment classification changes

If you become eligible for STD Top-Up Plan coverage as a result of an employment classification change, your coverage becomes effective the first of the month following one full calendar month of service in your new employment classification. You must also be actively at work the day coverage begins. If you are not actively at work the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a regular or fixed term position. For more information, see the "Actively at work definition" section on this page.

If you change employment classification from regular or fixed term to flexible, your STD Top-Up Plan coverage will end as of the classification change date. If you are receiving STD benefits as of your classification change date, you will continue to receive STD benefits until you are released to return to work or you are no longer approved for STD benefits.

Actively at work definition

"Actively at work" means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to work or travel or allows you to work. Actively at work also includes any normally scheduled days off work, observed holidays, Paid Time Off (PTO), and other paid time away that is recognized under Wells Fargo's time away policies (except for Military Duty time away).

When coverage ends

Your STD Top-Up Plan coverage ends on the earliest of the following dates:

- The day your last day of employment takes place
- The day you transfer to an ineligible employment classification or position, or your covered pay, referred to as "salary" in the Benefits section of Workday, falls below the compensation limit
- The first day you are away from work for a reason other than PTO, other paid time away that is recognized under Wells Fargo's time away policies, or an authorized leave during which eligibility for STD Plan participation continues (see the "Leave of absence" section on page 11-5)
- The day you begin a Military Leave or time away, Job Search Leave, Preferential Hiring Leave, or unpaid Administrative Leave
- The day you die
- The day the STD Top-Up Plan is discontinued or terminated

- The day you begin severance benefits under the Wells Fargo & Company Severance Plan on or after 1/1/2022

For information on Wells Fargo's ability to amend, modify, or terminate the STD Top-Up Plan at any time and for any reason, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

Coverage when you're not working

Leave of absence

Eligibility for STD Top-Up Plan coverage continues during the following types of leaves of absence*:

- Medical Leave, provided that:
  1. You were eligible to participate in the STD Top-Up Plan as of your last day worked.
  2. You have not received the maximum amount of STD benefits as shown on the "STD benefits schedule" on page 11-11.
- Workers' Compensation Leave**
- Family Leave
- Paid Administrative Leave
- Personal Leave
- Non-working Notice Leave
- Parental Leave
- Critical Caregiving Leave
- Job-Protected Paid Leave

You are not eligible for STD Top-Up Plan coverage during a Military Leave, Job Search Leave, Preferential Hiring Leave, unpaid Administrative Leave, or Job-Protected Unpaid Leave. This means that if you become disabled while on one of these leaves, you will not be eligible for STD benefits.

* If your claim for STD benefits has been denied and you continue to remain out of work due to your medically certified health condition (the health condition that was the basis for your denied claim) or for any other reason, you are not eligible to file a subsequent claim for STD benefits for this same health condition (excluding pregnancy) while you remain out of work even if you are on an approved leave of absence. However, you have the right to appeal the denied claim; see the "Filing an appeal" section on page 11-15.

**Wells Fargo provides the Texas Injury Benefit Plan, rather than Workers' Compensation, for Texas employees who have a work-related injury or illness. For Texas employees, references to "Workers' Compensation" shall mean the "Wells Fargo Texas Injury Benefit Plan."

How STD Top-Up benefits coordinate with leave of absences:

The STD Top-Up Plan provides pay continuation if you have a medically certified health condition and are unable to perform some or all of your job duties for more than seven consecutive calendar days. Generally, you will be on a leave of absence that runs concurrently to your short-term disability top-up benefits. A leave of absence is not part of the STD Top-Up Plan and has different requirements, including different forms and deadlines. The discussion of leaves in this section and the chart below is for informational purposes only and is not part of the STD Top-Up Plan or any other ERISA benefit sponsored by Wells Fargo.

For a	You'll need to provide:
Medical Leave of Absence	A Certification of Health Care Provider (DOC) form confirming that you are medically unable to work. Provide documentation, including the required certification, within 15 calendar days of the leave administrator's request. You may be required to provide recertification on a periodic basis. **Note:** If you submit a claim for short-term disability (STD) benefits concurrently with a Medical Leave request, you and your health care provider must provide additional medical documentation to support your STD claim. The Certification of Health Care Provider form submitted with your medical leave request does not provide enough information to support a short-term disability claim. An approved medical leave is unpaid until a short-term disability claim is approved.

Short-Term Top-Up Disability claim	You must provide additional medical documentation described in the "Proof of your disability" section on page 11-8 to support your STD claim. For more information, see "How to file a claim for STD benefits" section on page 11-6 Authorization forms: • Lincoln Authorization to Obtain and Release Information (PDF) • Kaiser Authorization to Disclose Health Information (PDF). The Certification of Health Care Provider form is used solely for the purpose of approving a Medical Leave, which is unpaid. In order to receive Short-Term Top-Up Disability pay during your medical leave, Lincoln will provide you with an Authorization to Obtain and Release Information form that authorizes your provider to share medical records with Lincoln Financial to evaluate your eligibility for STD Top-Up pay. You will need to sign the authorization form and send it to Lincoln or provide it directly to your treating provider. It is your responsibility to ensure that Lincoln receives the information in a timely manner. When medical records are not received timely, any STD Top-Up payments you may be eligible for may be delayed. See the "Proof of your disability" section on page 11-8 for more details.
Parental Leave	If you file a claim for maternity Short-Term Top-Up Disability benefits, then Parental leave supplements the benefits you may be eligible to receive under the STD Plan, if you meet the requirements for Parental Leave. Generally, parental leave runs concurrently with Short-Term Disability benefits. Lincoln will provide you with a Certificate of Care form for Parental Leave where you will self-designate as a primary or nonprimary caregiver. For more information on how the STD Top-Up Plan coordinates with Parental Leave, see the "STD Top-Up benefit amount" section on page 11-11.

How to file a claim for STD benefits

If your claim for STD benefits has been filed under the Wells Fargo STD Plan, you do not need to file a separate claim for STD benefits under the STD Top-Up Plan. Lincoln processes claims under both plans and will coordinate the claim determinations and any applicable benefit payments.

The general process to file a claim for STD benefits is noted below.

1. Call your supervisor

If you are unable to work your regular work schedule, you must speak to your supervisor immediately. If you are unable to personally speak to your supervisor, have someone else make the call. You don't need to share any medical information with your supervisor, but you should keep in regular contact with them about your leave status, including any extension of your leave, work restrictions, return to work date, and requested accommodations, if any.

If you are aware of an impending leave because of a planned medical procedure, you should provide your supervisor with at least 30 days' advance notice.

2. Call Lincoln

To file a claim for STD benefits for a health condition that is not due to a work-related illness or injury, you must file a claim with Lincoln. There are two ways to file your claim for STD benefits:

1. **Call our claims administrator, Lincoln, at** 1-866-213-2937.
2. **File online at Lincoln at** mylincolnportal.com. First-time users will need to establish a username and password by following the prompts on the screen. The company code for Wells Fargo is "wells."

You may report your claim for disability benefits up to 30 days in advance of the date your leave is to begin.

Proof of your disability is required for all claims and must be received by Lincoln within the designated time frame described in the "Proof of your disability" section starting on page 11-8. Proof may include medical records, test results, or hospitalization records as Lincoln deems necessary. If Lincoln has not received valid medical proof of your disability within the designated time frame, your request for STD benefits will be denied, including any benefits that might otherwise be available under the STD Top-Up Plan. For more information, see the "STD benefits schedule" on page 11-11 and the "Proof of your disability" section on page 11-8.

If your health condition is due to a work-related illness or injury, you must contact a Risk & Insurance Management Representative by calling 1-877-HRWELLS (1-877-479-3557), option 2,3,3 to file a separate Workers' Compensation claim.

If you return to work, and within 30 calendar days you miss work again because of a recurrence of your medically certified health condition, immediately contact all of the following:

- Your supervisor
- Lincoln, at 1-866-213-2937

For more information, see the "Recurrent condition" section on page 11-10.

A claim for STD benefits and Workers' Compensation for the same condition will be coordinated. Workers' Compensation is considered the primary source of income continuation if you have a health condition that is payable under both Workers' Compensation and the STD Top-Up Plan. STD Top-Up benefits will be reduced by your Workers' Compensation benefits (see the "Deductible sources of income" section on page 11-12 for more information). Claims for STD benefits are reviewed independent of claims for Workers' Compensation benefits.

3. Get the forms you need

The forms referenced below are available by calling Lincoln, at 1-866-213-2937.

Please include your Lincoln claim number and your first and last name on all correspondence sent to Lincoln. This allows Lincoln to expedite the review of any correspondence concerning your request for STD benefits.

Required forms

Complete the Authorization to Obtain and Release Information form and fax it to Lincoln at 1-866-214-7839 or mail it to the following address:

Lincoln Financial Group
Disability Claims
PO Box 2578
Omaha, NE 68172-9688

To expedite the processing of your claim, Lincoln may need to contact your physician to obtain medical information concerning your disability. Your physician cannot share medical information concerning your disability unless the authorization is on file with Lincoln. Failure to provide a completed authorization form may result in the denial of your claim for STD benefits.

While Lincoln will make attempts on your behalf to obtain your medical records, it is your responsibility to provide the required documentation. Your failure to provide medical information concerning your disability when required may result in the denial of your claim for STD benefits.

4. Provide valid medical information

The medical information you provide in support of your claim must be accurate. If the information is not accurate or the signature of the health care provider is not valid as determined by Lincoln, your claim for STD benefits will be denied or discontinued, you will be disqualified from participating in the STD Top-Up Plan, and you may be subject to further disciplinary action, including termination of employment.

5. Timely action required

Your STD benefits payments will be denied or discontinued if you or your health care provider does not supply, by the due date, all of the information about your condition requested by Lincoln.

How the STD Top-Up Plan works

STD waiting period

You may be eligible for STD benefits under the STD Top-Up Plan after you complete the STD waiting period. The STD waiting period is the seven-consecutive-calendar-day period beginning on the initial date of your medically certified health condition.

If you begin your leave with a reduced work schedule, the hours you have missed will not apply toward the waiting period.

If you return to work and attempt to complete one scheduled workday before the end of the STD waiting period, but you are unable to work at least half of your regularly scheduled workday due to your medically certified health condition, then the STD waiting period will be considered to have been uninterrupted. If you work one full day during your waiting period, your waiting period will start over.

Your time away from work during the STD waiting period is subject to Wells Fargo's time away programs, including required use of your accrued, unused Paid Time Off (PTO) or paid sick time (PST), as applicable during the STD waiting period for any scheduled work hours you miss. If you do not have accrued PTO or PST available, and your time away from work is not otherwise subject to income replacement under Wells Fargo's time away programs, the STD waiting period will be unpaid unless your business group allows employees to use unaccrued PTO from their current year's unaccrued PTO in which case you may use PTO allowance in accordance with your business group's policy.

If you are requesting STD benefits due to the birth of a child and you are the primary caregiver and have met the eligibility requirements for Parental Leave, you do not need to use PTO or PST to cover the STD waiting period. However, if you are not the primary caregiver and defer your Parental Leave to a later date or you are not yet eligible for Parental Leave, then the previous paragraph applies to you.

Qualifying for STD Top-Up Plan benefits

To qualify for STD benefits under the STD Top-Up Plan, you must:

- Be eligible for coverage under the STD Top-Up Plan.
- Be actively at work on the scheduled day before the onset of disability or on an approved leave of absence that is recognized by the STD Top-Up Plan (for example, a Medical Leave, Family Leave, Workers' Compensation Leave, or Personal Leave).
- Be considered disabled under the STD Top-Up Plan; that is, you must have a medically certified health condition that lasts longer than the STD waiting period and prevents you from performing the essential duties of your job.

- Be under the care of an approved care provider.
- Receive appropriate care and treatment for your medically certified health condition.
- File a claim for STD benefits within 90 days following your date of disability. Date of disability is generally defined as the first day that you are medically unable to work due to your condition and certification is received to validate that you meet the definition of disability as defined by the plan as of this date. For more information, see "How to file a claim for STD benefits" on page 11-6 and "5. Timely action required" on page 11-7.
- Receive approval of STD benefits in accordance with the provisions of the STD Top-Up Plan.

Even though you may qualify for disability income from other sources such as State Disability Insurance, you must satisfy all of the criteria of the STD Top-Up Plan before you will qualify for STD benefits under the Plan.

Medically certified health condition definition

For purposes of the STD Top-Up Plan, a medically certified health condition is generally defined as a disabling injury or illness that:

- Is documented by clinical evidence as provided and certified by an approved care provider. Clinical evidence may include medical records, medical test results, physical therapy notes, mental health records, and prescription records.
- Prevents you from performing the essential functions, duties, and regular schedule of your position as of the last day worked for longer than the STD waiting period.

Note: Not all conditions are covered; refer to the "Exclusions" section on page 11-14 for more information.

Pregnancy

Your date of disability will be considered your date of delivery (or the day after your delivery if you worked on the day you delivered). After you deliver your baby, you may be eligible for six or eight weeks of STD benefits which will include your one week for the STD waiting period (see the "STD waiting period" section on page 11-7 for more information). You may also be eligible for Parental Leave, which would allow you to receive income replacement beginning on the date of the delivery (Parental Leave is not part of this STD Top-Up Plan). See the "How the STD Top-Up Plan coordinates with Wells Fargo's Parental Leave" section on page 11-11 for more information.

If you experience complications during or after your pregnancy that result in an inability to work, you may be eligible for STD benefits before or after delivery based on the medical information provided to Lincoln. Disabling medical complications related to pregnancy are treated the same as any other disabling injury or illness under the STD Top-Up Plan. For example, fatigue associated with pregnancy may not qualify as a medically certified health condition under the STD Top-Up Plan unless your approved care provider documents the clinical evidence that the fatigue prevents you from performing the essential duties of your regular job. For more information, see the "Qualifying for STD Top-Up Plan benefits" section starting on page 11-7.

Valid medical information

The medical information you provide in support of your claim must be accurate. If the information is not accurate or the signature of the health care provider is not valid as determined by Lincoln, your claim for STD benefits will be denied or discontinued, you will be disqualified from participating in the STD Top-Up Plan, and you may be subject to further disciplinary action, including termination of employment.

Approved care provider definition

"Approved care provider" means a person who is legally licensed to practice medicine and is not you or related to you. A licensed medical practitioner will be considered an approved care provider if:

- Applicable state law requires that such practitioners be recognized for the purposes of certification of disability.
- The care and treatment provided by the practitioner are within the scope of his or her license.

An approved care provider includes a licensed Ph.D. psychologist or other licensed mental health practitioner.

Appropriate care and treatment definition

"Appropriate care and treatment" means medical care and treatment that meets all of the following criteria:

- It is received from an approved care provider whose training and experience are suitable for treating your medically certified health condition.
- It is necessary to meet your health needs and is of demonstrable medical value.
- It is consistent in type, frequency, and duration of treatment with relevant guidelines of national medical, research, and health coverage organizations.
- It is consistent with the diagnosis of your condition.
- Its purpose is to maximize your medical improvement.

Proof of your disability

It is your responsibility to ensure that Lincoln receives requested medical proof of your disability, which may include medical records, test results, and hospitalization records, within the designated time frame. If Lincoln has not received the requested medical documentation and valid medical proof within 30 days from the later of the date your claim was filed or your date of disability, your request for STD benefits will be denied. A claim for STD benefits must be filed no later than 90 days following your date of disability (see the "date of disability" definition in the "Qualifying for STD Top-Up Plan benefits" section starting on page 11-7).

You can file a claim for STD benefits beyond 90 days following your date of disability if you can show both of the following:

- It was not reasonably possible to give timely written proof of your claim for STD benefits. Such proof must be provided as soon as reasonably possible but in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required.

- Medical information supporting your claim for STD benefits satisfactory to Lincoln was provided as soon as was reasonably possible.

Benefits determination

The determination of a claim for STD benefits is based on one or more of the following:

- Medical information provided by your approved care provider or providers
- Professional opinions of other care providers as designated by Lincoln
- Other criteria as specified in this Chapter

You will receive written notification of the status of your claim for STD benefits within 45 days of Lincoln's receipt of your claim for STD benefits. You will receive only one determination (approval or denial) that applies to both the STD Plan and the STD Top-Up Plan.

Approvals

If your claim for STD benefits is approved, the letter will state the expected duration of your STD benefits, when updated medical information is due, or when benefits will stop. Approvals are retroactive to the first day you are medically certified to miss work after the STD waiting period. For more information, see the "Claims and appeals" section starting on page 11-14.

Denials

If Lincoln denies your claim for STD benefits in whole or in part, the notification of the claims decision will be provided to you and will state the reasons why your claim was denied and reference the specific plan provision or provisions on which the denial is based. You have the right to appeal this determination. For more information, see the "Claims and appeals" section starting on page 11-14.

After a claim for STD benefits has been denied, if you continue to remain out of work due to your medically certified health condition (the health condition that was the basis for your denied claim) or for any other reason, you are not eligible to file a subsequent claim for STD benefits for this same health condition (excluding pregnancy) while you remain out of work even if you are on an approved leave of absence. (However, you have the right to appeal the denied claim; see the "Filing an appeal" section starting on page 11-15.) Lincoln will notify you of the requirements for maintaining an approved leave of absence with Wells Fargo if your claim for STD benefits was denied and you continue to remain out of work due to your medically certified health condition. Failure to comply with those requirements may result in corrective action up to and including termination of your employment.

Disability case management

Lincoln will assign a disability case manager to provide case management services, to monitor your continuing eligibility for STD benefits, and to facilitate your timely return to work. Your Lincoln Case Manager will monitor the payment of your STD benefits to ensure that your benefit is being processed correctly. It is your responsibility to keep Lincoln and your supervisor informed with updates about your leave status.

Confidentiality of medical information

Medical information about your diagnosis, treatment plan, and care provider will be kept confidential by Lincoln, unless your file is released to the plan administrator or its designee in connection with an appeal. Lincoln may release medical information to a third-party vendor or to your treating providers as it pertains to your claim for disability benefits. Such information will not be disclosed to your supervisor without your consent or made part of your personnel file.

With your written consent, information may be shared with Wells Fargo as it pertains to administration of your leave (Leave Disability Management), as it pertains to your return to work (Accommodations Management), or as it pertains to mental health referrals (Employee Assistance Consulting). Information about your dates of leave, eligibility for STD benefits, return to work dates, work restrictions, requested accommodation, or any combination thereof may be provided to your supervisor or Human Resources consultant and may be noted in your personnel file.

Medical evaluations and treatment plans

Your approved care provider should establish a detailed treatment plan to assist you in your recovery and continue to provide proof of your disability to Lincoln. Before you can return to work, Lincoln and your supervisor must receive a signed confirmation of your release to return to work from your approved care provider. Your release must explain any requested accommodations or work restrictions.

Independent medical examinations

Lincoln may request another care provider to examine you. This is called an "independent medical examination." The purpose of this exam is to obtain additional information about your condition and treatment plan for the purpose of determining your eligibility for STD benefits. Lincoln chooses the care provider who examines you and pays for the examination. In some cases, more than one independent medical examination may be required. Your refusal to attend or cooperate with the independent medical examination may result in a denial or discontinuation of STD benefits.

In some cases, STD benefits may be stopped at the time the independent medical examination is ordered until the results of the independent medical examination are received and a decision can be made about your eligibility for STD benefits. After your eligibility for STD benefits is approved, STD benefits will be reinstated retroactive to the date benefits stopped.

Additional evaluations

Lincoln may also request that you receive additional evaluations, which may include rehabilitation, functional, psychological, or vocational evaluations. These evaluations are also used to determine your health status and ability to work. You are required to participate in these evaluations to receive or to continue receiving STD benefits. These evaluations will be provided at no cost to you.

On-site medical case management

Lincoln may contract with an on-site medical case manager to assist you and your Lincoln disability case manager to facilitate your timely return to work. The on-site medical case manager may accompany you to medical appointments, review and coordinate care and treatment, visit your home and workplace, and communicate with your care providers, supervisor, Human Resources consultants, and your Lincoln disability case manager. You are required to cooperate with on-site medical case management to continue receiving STD benefits.

Recurrent condition

If your medically certified health condition starts again within 30 calendar days after you have been released to return to work, your condition may be considered a recurrent condition. A recurrent condition is due to the same cause or complication resulting from the initial medically certified health condition. It will be treated as a continuation of your initial medically certified health condition, and you will not have to satisfy a new STD waiting period. The maximum amount of time you may receive STD Top-Up benefits for the same condition is 26 weeks, which includes the STD waiting period.

If your medically certified health condition starts again 30 calendar days or more after you have been released to return to work on a full-time basis, it will be treated as a new condition under the STD Top-Up Plan, provided you are still eligible for coverage under the Plan. If that is the case, you will be required to satisfy a new waiting period.

Your covered pay, referred to as "salary" in the Benefits section of Workday, for purposes of determining your STD Top-Up benefit will be based on your covered pay at the time the condition originally started, versus when the condition starts again, unless you are required to file a new claim or satisfy a new STD waiting period (see the "Covered pay" section on page 11-11).

If you are disabled and working (reduced work schedule)

A reduced work schedule is an accommodation provided to you by your supervisor, Wells Fargo Accommodations Management, or both if you have proof of a disability that prevents you from working 100% of your predisability standard hours as documented by your health care provider. All accommodations must be reviewed and approved by your supervisor, Wells Fargo Accommodations Management, or both.

STD benefits may be paid in combination with the earnings you receive while on a reduced work schedule based on the applicable percentages and time periods described in the "STD benefits schedule" on page 11-11. As a result, in addition to your reduced work schedule earnings, you may receive STD benefits up to your eligible STD Top-Up benefit amount reduced by other sources of income (see the "Deductible sources of income" section on page 11-12). To be eligible to receive STD Top-Up benefits on a reduced work schedule, you must satisfy the waiting period and be earning between 20% and 80% of your covered pay, referred to as "salary" in the Benefits section of Workday.

Reduced work schedule STD pay examples

- Example 1 for employees who have satisfied the STD waiting period and who are eligible for an STD Top-Up benefit of 65% of their covered pay, referred to as "salary" in the Benefits section of Workday[1] (and are not receiving any sources of income other than the reduced work schedule earnings)
  - If your normal biweekly pay amount is $11,500 as an employee working 40 hours per week
    - At a 65%[1] STD benefit level, your maximum STD benefit would be $7,475 biweekly
  - If, on the reduced work schedule, you work 20 hours per week and earn $5,750 biweekly (for your hours worked)
    - The remaining eligible STD benefit would be $1,725 biweekly (the $7,475 STD maximum benefit minus the $5,750 biweekly pay for hours worked)[2]

1. Your eligible STD benefit amount is based on the "STD benefits schedule" noted on page 11-11.
2. The portion of your benefit attributable to the amount of your covered pay that exceeds the compensation limit is paid from this STD Top-Up Plan.

- Example 2 for employees who have satisfied the STD waiting period and who are eligible for an STD benefit of 100% of their eligible covered pay[1] (and are not receiving any sources of income other than the reduced work schedule earnings)
  - If your normal biweekly pay amount is $11,500 as an employee working 40 hours per week
    - At a 100%[1] STD benefit level, your maximum STD benefit would be $11,500 biweekly
  - If, on the reduced work schedule, you work 20 hours per week and earn $5,750 biweekly (for your hours worked)
    - The remaining eligible STD benefit would be $5,750 biweekly (the $1,000 STD maximum benefit minus the $500 biweekly pay for hours worked)[2]

1. Your eligible STD benefit amount is based on the "STD benefits schedule" noted on page 11-11.
2. The portion of your benefit attributable to the amount of your covered pay that exceeds the IRC determined maximum annual compensation limit is paid from this STD Top-Up Plan.

STD Plan benefits

Generally, STD benefits replace either 65% or 100% of your covered pay, referred to as "salary" in the Benefits section of Workday, for up to 25 weeks, after completion of the STD waiting period, based on your completed years of service, as shown in the table below. For information on covered pay, see the "Covered pay" section starting on this page.

Note: Your STD waiting period of the first seven consecutive days counts toward the 26 weeks.

STD benefits schedule

Completed years of service	Weeks at 100% of covered pay*	Weeks at 65% of covered pay*
Less than 1 year – 3 years	4 weeks	21 weeks
4 – 6 years	7 weeks	18 weeks
7 – 9 years	13 weeks	12 weeks
10 or more years	25 weeks	None

* After completion of the STD waiting period (see the "STD waiting period" section on page 11-7 for more information).

Completed years of service

For STD benefits, your completed years of service are measured from your Continuous Service Date as explained in Workday and Payroll System. You are credited with one year of service after each full 12-month period of employment is completed.

Covered pay

If you meet the criteria for STD benefits, your benefits are based on covered pay, referred to as "salary" in the Benefits section of Workday, in effect on the day before the initial date of your disability. Your covered pay is determined by the job classification code (job class code) for your position in Workday. Only the portion of your covered pay that exceeds the compensation limit for benefits under the STD Plan counts as covered pay under the STD Top-Up Plan. To view your STD covered pay, log into Workday and go to View Profile, then choose Actions, then choose Benefits, and View STD Covered Pay under Benefits Annual Rate.

Job class code 2

Most positions within Wells Fargo are job class code 2. For job class code 2 positions, covered pay, referred to as "salary" in the Benefits section of Workday, is defined by your annual base salary. Annual base salary is your hourly rate of pay (including geographical differentials, if applicable) multiplied by the number of standard hours indicated in Workday and takes into account the number of working days each calendar year. The amount is multiplied by the number of weeks in a calendar year to determine your annual base salary. Base salary may be expressed as an annual, monthly, or hourly rate. Base salary includes amounts designated as before-tax contributions you make to Wells Fargo's sponsored benefit plans, but it does not include overtime pay, shift differentials, language differentials, incentives, bonuses, commissions, or perquisites such as parking or auto allowances or commute subsidies.

STD Top-Up benefit amount

STD benefits are generally based on your covered pay, referred to as "salary" in the Benefits section of Workday, in effect on the day before the initial date of your disability, and on your completed years of service on the first day of your disability, as shown in the "STD benefits schedule" above. Only the portion of your covered pay that exceeds the compensation limit under the STD Plan is taken into consideration in calculating your STD benefit amount under the STD Top-Up Plan.

The following statement is for informational purposes only and is not part of this STD Top-Up Plan SPD: The portion of your covered pay, referred to as "salary" in the Benefits section of Workday, that falls below the compensation limit will be considered for benefits under the Wells Fargo & Company STD Plan (see "Chapter 10: Short-Term Disability Plan" for more information).

How the STD Top-Up Plan coordinates with Wells Fargo's Parental Leave

This section is for informational purposes only and is not part of the STD Top-Up Plan or any other ERISA benefit sponsored by Wells Fargo & Company.

Parental Leave supplements the benefits you may be eligible for under the STD Top-Up Plan if the condition for which you are requesting STD benefits is due to the birth of your child and your claim is approved.

- If you are eligible for 100% benefits under this STD Top-Up Plan and STD Plan combined (offset by deductible sources of income as noted below), generally you would not receive income replacement via Parental Leave for the time period that the STD Top-Up Plan and STD benefit combined runs concurrent to the Parental Leave.

- If you are eligible for 65% benefits under this STD Top-Up Plan and STD Plan combined (offset by deductible sources of income as noted below), your concurrent income replacement under Parental Leave will be reduced accordingly, and you will only receive 35% of your income replacement under Parental Leave for the time period that the STD Top-Up Plan and STD benefit combined runs concurrent to Parental Leave.

You will never receive more than 100% of your predisability covered pay. For more information about Parental Leave, refer to Service Now or call Lincoln Financial at 1-866-213-2937.

Deductible sources of income

You will never receive more than 100% of your predisability covered pay. Your STD benefit automatically will be reduced by the amount of income you receive (or are eligible to receive) from other sources, including but not limited to:

- Statutory benefits, such as state-mandated disability benefits.
- Workers' Compensation benefits attributed to lost income, including a settlement awarded to you.
- Automobile or other type of accident wage replacement income.
- Income while you are working under an approved reduced work schedule.
- Any income received for disability under a government compulsory benefit or program that provides for loss of time from your job due to your disability, whether such payment is made directly by the plan or program or through a third party (including but not limited to Social Security disability, retirement, and dependent's benefits, but excluding survivor benefits).
- Third-party recovery for loss of income by judgment, settlement, or otherwise, including recovery amounts you may receive from future earnings as permitted by state law.

If you work in a state or commonwealth with a mandatory disability program (currently California, Hawaii, Massachusetts, New Jersey, New York, Puerto Rico, Rhode Island, Washington State, and Washington D.C.), it is your responsibility to apply for statutory benefits for most states. Lincoln will file temporary disability benefits with Hawaii, New Jersey, and New York on your behalf.

If your employment is terminated before the date you become disabled, you will not be eligible for STD Top-Up coverage.

Payment of STD benefits

Once the plan administrator receives notification from Lincoln that your STD claim meets the criteria for approval, all STD benefits will be paid through the Wells Fargo regular biweekly payroll system. Your benefits under this Top-Up Plan will be combined with your benefits under the STD Plan in a single check. Your regular benefit deductions will continue to be taken from your STD benefits in accordance with the provisions of the other Wells Fargo plans in which you participate. In some instances, your health benefit deductions may not be included in your disability check. In these cases, you may be billed later. You should review each payment to ensure that the appropriate deductions have been taken for your health benefits. (See the reference to "covered pay" in the "Covered pay" section on page 11-11.)

Recovery of overpayment

If you receive excess STD benefits, including STD Top-Up Plan benefits, because you receive income from one of the deductible sources described in the "Deductible sources of income" section or due to a miscalculation of your benefit amount, the STD Top-Up Plan or the plan administrator or its designee reserves the right to seek full reimbursement of the amounts overpaid, including but not limited to offsetting any future STD Top-Up benefits by the amount overpaid.

Right of recovery

When your injury or sickness appears to be someone else's fault, benefits otherwise payable under the STD Top-Up Plan for loss of time as a result of that injury or sickness will not be paid unless you or your legal representative agree to the following:

- To repay the STD Top-Up Plan for such benefits to the extent they are for losses for which compensation is paid to you by or on behalf of the person at fault.
- To allow the STD Top-Up Plan to place a lien on such compensation and to hold such compensation in trust for the STD Top-Up Plan.
- To execute and give to the plan any instruments needed to secure the rights under the first two conditions, above.

Further, when the STD Top-Up Plan has paid benefits to you or on your behalf, the STD Top-Up Plan may be subrogated to all rights of recovery that you have against the person at fault. These subrogation rights will extend only to recovery of the amount the STD Top-Up Plan has paid. You must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the STD Top-Up Plan.

You must also agree not to take any action that is inconsistent with the STD Top-Up Plan's right to reimbursement. Reimbursement will be made regardless of whether you are fully compensated, or "made whole," by the settlement, verdict, judgment, award, or insurance proceeds and regardless of whether costs are allocated to "loss of income." The STD Top-Up Plan will not be responsible for bearing the cost of any legal fees you incur as a result of any action you take against the third party.

If you refuse to fully reimburse the STD Top-Up Plan after receipt of a settlement, verdict, judgment, award, or insurance proceeds, the STD Top-Up Plan may not pay for any future benefits. The STD Top-Up Plan may seek legal action against you to recover paid benefits related to your injury or condition. In addition, the STD Top-Up Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent benefits are paid by the STD Top-Up Plan.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator, in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Taxes on STD benefits

STD benefits are taxable income. Wells Fargo withholds federal, state, local, and Social Security taxes from your STD benefits.

When STD benefits end

Generally, the maximum amount of time you may receive STD benefits for the same condition is 25 weeks after completion of the STD waiting period. STD benefits may end sooner if you are unwilling or fail to do any one of the following:

- Provide medical evidence in a timely manner.
- Provide requested medical records.
- Receive continuing care and treatment from an approved care provider, appropriate to your condition, during the time period for which STD benefits are requested.
- Participate in additional medical and other evaluations requested by Lincoln. For more information, see the "Medical evaluations and treatment plans" section on page 11-9.
- Cooperate with on-site medical case management.
- Follow the prescribed treatment plan.
- Follow approved work restrictions or accommodations.
- Return to work when medically certified to do so.
- Accept the same or equivalent offer of employment within your medical restrictions.
- Begin working for wage or profit if not under an approved reduced work schedule.

In addition, your STD benefits may end:

- If your employment is terminated for any reason.
  Note: If you are notified of a qualifying event under the Wells Fargo & Company Severance Plan and are receiving STD benefits during the notice period or prior to your severance eligibility period, STD benefits will be paid until benefits end (up to 25 weeks).
- The date your weekly earnings exceed 80% of your predisability covered pay, referred to as "salary" in the Benefits section of Workday.
- The day you receive the maximum amount of STD benefits, as shown in the "STD benefits schedule" on page 11-11, for the same or related health condition that gave rise to your STD claim.

Survivor benefit

If you die while receiving STD benefits, your beneficiary will be eligible for a lump sum benefit payment in an amount equal to 10 times your predisability biweekly covered pay, referred to as "salary" in the Benefits section of Workday, based on your covered pay in effect on the day before the initial date of your disability. For example, if you are an employee who has a covered pay amount of $350,000 per year, you would calculate $350,000 per year divided by 26 weeks to get a $13,461.54 biweekly rate.

To calculate the survivor benefit, take this amount and multiply it by 10 to get $134,615.40. In this example, $134,615.40 would be paid to your designated beneficiary at the time of your death. However, only the portion of your covered pay that exceeds the IRC determined maximum annual compensation limit will be paid from the STD Top-Up Plan. Your beneficiary will receive one check for the amount payable from both the STD Plan and STD Top-Up Plan combined. It's important to note that the survivor benefit under either plan will be reduced by any overpayment of STD benefits that may exist. Taxes will not be withheld from your survivor benefit. Your estate or the benefit recipient may, however, be required to pay additional taxes to the state or federal government. Consult a tax advisor for tax information related to your survivor benefit.

You will be asked to name one or more beneficiaries when you enroll in benefits, using the online Beneficiary Designation Tool in Workday.

If you need to change your beneficiaries during the year, you may do so at any time by going to the Beneficiary Designation Tool in Workday.

If a beneficiary is not designated, the beneficiary dies before you and no contingent beneficiary was named, or the contingent beneficiary has also died before you, the death benefit is paid to your survivors in the following order:

1. Your surviving spouse or domestic partner[1]
2. Equally among your surviving biological and adopted children[2]
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

1. See the "Definitions relating to marital status" section starting below for more information.
2. Except that if any of the participant's children predecease him or her but leave descendants surviving, such descendants shall take by right of representation the share their parent would have taken, if living.

To qualify for a survivor benefit, the following conditions must be met:

- You completed the STD waiting period.
- You were eligible to receive STD benefits at the time of your death.
- You were not working a reduced work schedule due to your disability.
- Proof of your death is provided to Wells Fargo.

If your beneficiary disagrees with the determination on your eligibility or the amount of the survivor benefit, your beneficiary has the right to request and obtain a copy of this SPD.

Upon your beneficiary's written request, the plan administrator will provide, free of charge, copies of documents, records, and other information relevant to your survivor benefit.

Definitions relating to marital status

For payment of a benefit if there are no surviving or designated beneficiaries, the following terms have the meanings assigned to them below:

- "Spouse" means the person to whom you are legally married on your date of death under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, or the person who was your current common-law spouse on your date of death in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages.
- "Domestic partner" means a person of the same or opposite gender who is not your spouse as defined above, that meets at least one of the following criteria on your date of death:
  - You and the person are joined in a civil union (or other similar formal relationship) on your date of death that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the union was created but is not denominated or recognized as a marriage under the laws of that state or country.
  - You and the person share a domestic partnership (or other similar formal relationship) on your date of death that is registered by a city, county, state, or country but is not denominated or recognized as a marriage under the laws of that city, county, state, or country.
  - You and the person both meet all of the following requirements:
    i. You shared a single, intimate, committed relationship of mutual caring as of your date of death intended to remain in the relationship indefinitely.
    ii. You resided together in the same residence and lived in a spouse-like relationship prior to your date of death.
    iii. You are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which you reside.
    iv. Neither of you was married to another person under either federal, state, or common law, and neither is a member of another domestic partnership.
    v. You were both mentally competent to consent or contract.
    vi. You were both 18 years old.
    vii. You were financially interdependent, jointly responsible for each other's basic living expenses, and, if asked, your partner is able to provide documentation for three of the following being in effect as of your date of death:
      A. Joint ownership of real property or a common leasehold interest in real property
      B. Common ownership of an automobile
      C. Joint bank or credit accounts
      D. A will that designates the other as primary beneficiary
      E. A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other
      F. Designation of one partner as holding power of attorney for health care decisions for the other

Exclusions

Not all conditions are covered by the STD Top-Up Plan. STD benefits will not be paid for any condition that is caused by or results from:

- Your commission or attempted commission of any criminal act, including but not limited to an assault, battery, felony, or any combination thereof
- Injuries you sustain or illness contracted while you are performing services for, or receiving compensation from, the military
- A cosmetic surgery or elective procedure, unless the surgery or procedure is:
  - Performed in connection with, or as a result of, a covered injury, accident, or illness in which the surgery or procedure is required due to reconstruction or medical necessity
  - Gender reassignment-related services (pre- and post-surgery)
  - Performed in connection with organ donation

Claims and appeals

Filing a claim

For information on how to file a claim for STD benefits, see the "How to file a claim for STD benefits" section starting on page 11-6. It is important to note that there is a claims filing deadline. You may report your claim for disability benefits up to 30 days in advance of the date your leave is to begin (for example, if you have a planned surgery), and you must file your claim for STD benefits no later than 90 days following your date of disability (see the "date of disability" definition in the "Qualifying for STD Top-Up Plan benefits" section starting on page 11-7).

Claim determinations, determination extension, and requests for additional information

After you submit a claim for STD benefits, Lincoln will review your claim and notify you of its decision to approve or deny your claim. Such notification will be mailed to you within a reasonable period, not to exceed 45 days from the date you submitted your claim, except for situations requiring an extension of time because of matters beyond the control of the STD Top-Up Plan. In such cases, Lincoln may have up to two additional extensions of 30 days each to provide you such notification.

If Lincoln needs an extension, it will notify you before the expiration of the initial 45-day period (or before the expiration of the first 30-day extension period if a second 30-day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of Lincoln's notice requesting additional information and an extension until Lincoln receives the requested information does not count toward the time period that Lincoln is allowed to notify you of its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting additional information from Lincoln.

Content of the claim determination notice

As noted in the "Claim determinations, determination extension, and requests for additional information" section on page 11-14, you will receive notice of the claim determination. An adverse benefit determination is a denial of your claim in whole or in part. Adverse benefit determinations will contain a complete discussion on why the claim was denied. If you receive an adverse benefit determination, the notice will provide the following information:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the determination is based.
- If the claim is denied because Lincoln did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.
- If an internal rule, protocol, guideline, or other criterion was relied upon to make the determination, the decision will state the internal rule, protocol, guideline, or other criterion or indicate that a copy of such rule, protocol, guideline, or other criterion will be provided free of charge to you upon request.
- If the adverse determination is based on medical necessity, experimental treatment, or similar exclusion or limit, you will receive an explanation of scientific or clinical judgment for the determination, applying the plan terms to the claimant's medical circumstances or a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request.
- An explanation of the basis for disagreeing (or not) with any of the following information:
  - The views presented by the claimant of treating health care professionals or vocational professionals who evaluated you
  - The views of the medical or vocational experts whose advice was obtained in connection with the decision, whether or not relied upon
  - A Social Security disability benefit determination presented by you
- A description of the plan's claim appeal review procedures (including the time limits applicable to such procedures) and a statement regarding your right to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended (ERISA) Section 502(a) following an adverse benefit determination on appeal.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
- Any additional information required under applicable law.

For information on filing an appeal under the STD Top-Up Plan, see the "Filing an appeal" section starting on this page.

Filing an appeal

If Lincoln denies your STD claim in whole or in part, you believe you should be entitled to a different amount of STD benefits, or you disagree with any determination that has been made reflecting your STD benefits, you (or your authorized representative) may appeal the decision. You (or your authorized representative) must file your appeal in writing within 180 days of the date you receive Lincoln's written adverse benefit determination of your claim, regardless of any discussions or consultations about the claim. If you file an appeal under the STD Plan, you do not need to file a separate appeal for STD benefits under the STD Top-Up Plan. There is one level of appeal for STD benefits which is reviewed by Lincoln. You or your duly authorized representative must sign your appeal request. It should be sent to Lincoln by U.S. mail to the following address:

Lincoln Financial Group
Disability Claims
PO Box 2578
Omaha, NE 68172-9688

The address for filing an appeal is also noted in Lincoln's adverse benefit determination letter.

Your appeal must be submitted in writing to Lincoln and must include at least the following information:

- Your name
- Your claim number
- Name of plan (that is, the Wells Fargo & Company STD Plan and STD Top-Up Plan)
- Reference to the initial determination
- An explanation of why you are appealing the determination

As part of your appeal, you may submit any additional written comments, documents (including additional medical information), records, or other information relating to your appeal that supports your request for benefits. Upon your written request, Lincoln will provide you free of charge with copies of documents, records, and other information relevant to your initial claim. A request for this information does not, however, extend the time frame you have to file your appeal.

The appeal process is your opportunity to present documentation and evidence to show that your claim for benefits is covered and payable under the plans. However, the review process does not permit you, your beneficiary, or your authorized representative to appear in person before, or meet with, anyone from Lincoln. It is your responsibility to submit any information or documentation that you wish to have considered for the appeal review within the required time frame. Please note that Lincoln does not reimburse fees that may be associated with filing the appeal or with your obtaining information you wish to have reviewed in support of your appeal.

After Lincoln receives your written, timely filed appeal request, it will conduct a full and fair review of your appeal. The reviewer will look at the claim anew, and no deference will be given to the prior denial. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination of your claim.

In addition, the person who will review your appeal will not be the same person who reviewed your claim or a subordinate of the person who made the initial decision to deny your claim (in whole or in part). If the initial denial is based in whole or in part on a medical judgment, the reviewer will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

Note: It is very important that you submit all of the information you want reviewed when your appeal is filed. The date the appeal is filed is the date it is received by Lincoln. Lincoln must make the appeal determination within the time frame stated below based on the date that you file your appeal regardless of whether you indicate more information to be forthcoming.

Lincoln will provide you, free of charge, with copies of any new or additional evidence or rationale considered, relied upon, or generated in connection with the claim appeal review as soon as possible and sufficiently in advance of the date on which the notice of final benefit determinant is required to be provided to you (to give you a reasonable opportunity to respond prior to that date). After you receive the information, if you feel there is a need, you may submit additional information to Lincoln for final consideration in the appeal review process (such information must be submitted before the final determination is due). Lincoln must consider any response from you as part of its decision making process, provided it is submitted before the final determination is due.

Appeal determination

After you file your appeal for disability benefits with Lincoln, it (or its designated representative) will review your appeal and notify you of its decision to approve or deny your appeal. This notification will be mailed to you within a reasonable period, but no later than 45 days after Lincoln's receipt of your written request for appeal review, except for situations requiring an extension of time because of matters beyond the control of the Plan. If an extension is required, Lincoln may have up to an additional 45 days to provide you with notification of the final decision. If such an extension is needed, Lincoln will notify you before the expiration of the initial 45-day period, state the reason or reasons why the extension is needed, and state when it will make its determination. You will have 45 days to provide any requested information from the date you receive the notice from Lincoln.

If Lincoln denies your claim on appeal in whole or in part (an adverse benefit determination), it will send you a final written decision. The notification of the decision will provide the following information:

- The specific reason or reasons why your appeal was denied.
- Reference to the specific Plan provision or provisions on which the denial was based.
- If the appeal was denied because sufficient information was not provided, a description of the additional information needed and an explanation as to why it was needed.
- An explanation of the basis for disagreeing (or not) with any of the following information:
  - The views presented by the claimant of treating health care professionals or vocational professionals who evaluated you
  - The views of the medical or vocational experts whose advice was obtained in connection with the decision, whether or not relied upon
  - A Social Security disability benefit determination presented by you
- If an internal rule, protocol, guideline, or other criterion was relied upon to make the determination, the decision will state the internal rule, protocol, guideline, or other criterion or indicate that a copy of such rule, protocol, guideline, or other criterion will be provided free of charge to you upon request.
- If the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation of the scientific or clinical judgment will be provided free of charge upon request.

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
- If applicable, a description of the plan's additional claim appeal review procedures (including the time limits applicable to such procedures).
- A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.
- A description of any applicable contractual limitations period and its expiration.
- Any additional information required under applicable law.

If you wish to receive copies of documents, records, and other information relevant to the final appeal decision, send Lincoln your written request for documents, records, and other information.

Legal action

With limited exceptions for violations of claim procedure regulations, no legal action can be filed against the Plan until the Plan's claims and appeals procedures have been exhausted (refer to the "Claims and appeals" section starting on page 11-14 for more information). Any suit for benefits must be brought within one year from the date the final appeal determination was issued by Lincoln.

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Chapter 12: Long-Term Disability Plan

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Contacts

To file a claim or for information about your existing claim	Lincoln Financial Group (Lincoln) 1-866-213-2937
To fax documentation about your claim	Lincoln 1-866-214-7839
Information about the Long-Term Disability (LTD) Plan	HR Services & Support site Lincoln 1-866-213-2937 wellsfargo@lfg.com
Information about premiums for the LTD Plan	Check your enrollment materials, or go to the HR Services & Support site.

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Important Notifications and Disclosures," and "Appendix D: Leaves of Absence and Your Benefits" — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company fixed term Disability Plan (the LTD Plan) that covers regular and fixed term Wells Fargo employees.

The basics

General information

The LTD Plan is designed to provide disability benefits if you are disabled for more than 26 weeks. The SPD and Group Disability Income Policy issued by Lincoln Financial Group (Lincoln), along with any certificates, policy amendments, riders, and endorsements, constitute the official plan documents for the LTD Plan. If there are any differences between the SPD and the LTD Plan policy, the LTD Plan policy governs your right to benefits. The LTD Plan is insured by Lincoln Financial Group and is classified as a "welfare benefit plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Generally, under Basic LTD coverage, LTD benefits replace 50% of your covered pay, referred to as "salary" in the Benefits section of Workday.

You can also choose to elect Optional LTD coverage, which provides LTD benefits that replace an additional 15% of your covered pay (Basic and Optional LTD together replace a combined total of up to 65% of your covered pay). The maximum covered pay for LTD benefits is $500,000 (see the "Covered pay" section on page 12-6).

LTD benefits coordinate with (and will be reduced by) other disability income benefits that you may be entitled to (see the "Deductible sources of income" section on page 12-7). Many of the terms used in this chapter have been specifically defined. Some terms are defined throughout the chapter; others are defined at the end in the "" section starting on page 12-15.

Insurer and claims administrator

The LTD Plan is insured and administered by Lincoln Financial Group (Lincoln). Lincoln has the discretionary authority to administer claims and interpret benefits under the LTD Plan.

Who's eligible

Eligible employees

You are eligible for Basic LTD coverage and Optional LTD coverage if you are a regular or fixed term Wells Fargo employee as described in "Chapter 1: Eligibility, Enrollment, and More."

Ineligible employees

You are not eligible to participate in the LTD Plan if you are:

- Classified as an intern or flexible employee.
- An employee of a Wells Fargo affiliate not participating in the LTD Plan.
- A person whom Wells Fargo classifies as an independent contractor or any other status by which you are not treated as a common-law employee of Wells Fargo for purposes of withholding taxes, regardless of your actual status. (This applies to all periods of such service of an individual who is subsequently reclassified as an employee, whether the reclassification is retroactive or prospective.)
- A regular or fixed term employee who is on certain types of leaves of absence (see "Appendix D: Leaves of Absence and Your Benefits.")
- A person whom Wells Fargo has classified as a legacy Wachovia employee with a date of disability prior to January 1, 2010.
- A person whom Wells Fargo classifies as an international employee.

Cost

Basic LTD

Wells Fargo pays the cost of your Basic LTD coverage.

Optional LTD

If you choose to enroll for Optional LTD coverage, you are responsible for the full cost of the additional coverage, and premiums will be deducted from your pay each pay period. Deductions will be taken on an after-tax basis. Premiums are based on your age and covered pay, referred to as "salary" in the Benefits section of Workday. If your age or covered pay changes, your premium will be adjusted accordingly. If you are approved for LTD benefits under your Optional LTD coverage, your Optional LTD premiums will be waived for the duration of your approved LTD claim. As an after-tax benefit, you can make this change at any time in Workday by going to Change Benefits and selecting Voluntary Drop After Tax Benefits. Changes will go into effect on the first day of the following month (see the "Covered pay" section on page 12-6).

How to enroll

Initial enrollment

Basic LTD

You are automatically enrolled for Basic LTD coverage if you are one of the following:

- A newly hired regular or fixed term employee
- An employee who has had an employment classification change to a regular or fixed term position
- A rehired regular or fixed term employee

Optional LTD

If you are eligible for Basic LTD coverage as described above, you may enroll for Optional LTD coverage during your designated enrollment period; see the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

Late enrollment

You may also enroll at any point during the year with a completed Evidence of Insurability form as approved by Lincoln. For more information or to request a paper copy of an Evidence of Insurability form, call Lincoln at 1-866-214-7839.

Annual Benefits Enrollment

If you did not enroll in Optional LTD coverage during your initial enrollment period, you may enroll in Optional LTD coverage during the Annual Benefits Enrollment period. Generally, coverage is effective the following January 1. However, you must be actively at work before your coverage is effective. For a definition of actively at work, refer to the "Actively at work definition" section on page 12-5. However, a preexisting condition exclusion may apply to your Optional LTD coverage (see the "Preexisting conditions" section on page 12-6).

When coverage begins

New hires or newly eligible employees

For regular and fixed term employees, Basic LTD coverage — and Optional LTD coverage, if elected during your designated enrollment period — begins on the first of the month after one full calendar month of service. If you are not actively at work on the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a regular or fixed term position. For more information, see the "Actively at work definition" section on page 12-5.

If you were previously employed by a company that was acquired by or merged with Wells Fargo, certain transition rules may apply to your eligibility for Basic and Optional LTD coverage under the LTD Plan when you first become an employee as a result of the acquisition or merger.

Rehired employees

If you are rehired into a regular or fixed term position within the six-month period following your termination date, your coverage will be reinstated at the same level that was in effect on your termination date.

If you are rehired into a regular or fixed term position after the six-month period following your termination date, Basic LTD coverage — and Optional LTD coverage, if elected during your designated enrollment period — begins the first of the month after one full calendar month of service if you are actively at work on the date coverage is scheduled to begin.

In either case, if you are not actively at work on the date coverage normally starts, your LTD coverage will not begin until you return to being actively at work and complete at least one full workday. You may be considered actively at work if it is your normally scheduled day off, on an observed holiday, or on Paid Time Off (PTO). For more information, see the "Actively at work definition" section on page 12-5.

Employment classification changes

If you change your employment classification to a regular or fixed term employee and become newly eligible for benefits, Basic LTD coverage — and Optional LTD coverage, if elected during your designated enrollment period — begins the first of the month after one full calendar month of service if you are actively at work on the date coverage is scheduled to begin.

If you are not actively at work on the date coverage normally starts, your LTD coverage will not begin until you return to being actively at work and complete at least one full workday. For more information, see the "Actively at work definition" section on page 12-5.

If you change employment classification from regular or fixed term to flexible, your Basic LTD coverage and Optional LTD coverage (if applicable) will end as of the classification change date. If you are receiving LTD benefits as of your classification change date, you will continue to receive LTD benefits until you are released to return to work or you are no longer approved for LTD benefits.

Annual Benefits Enrollment

If you enroll in Optional LTD during Annual Benefits Enrollment, generally, coverage is effective the following January 1. However, you must be actively at work before your coverage is effective. For a definition of actively at work, refer to the "Actively at work definition" section on page 12-5. However, a preexisting condition exclusion may apply to your Optional LTD coverage (see the "Preexisting conditions" section on page 12-6).

Reinstatement after a leave of absence

For information, see the "Coverage when you're not working" section on page 12-11.

Actively at work definition

"Actively at work" means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to work or travel, or allows you to work. Actively at work also includes any normally scheduled days off work, an observed holiday, or PTO.

How the LTD Plan works

LTD waiting period

While you are covered by the LTD Plan, you may be eligible for LTD benefits after you complete the LTD waiting period. The waiting period is the 26-week period of continuous or partial disability as measured from your initial date of disability. Date of disability is generally defined as the first day that you are medically unable to work due to your condition and certification is received to validate that you meet the definition of disability as defined by the plan as of this date. Time spent working a reduced work schedule due to a disability may apply toward the 26-week waiting period if you are unable to earn more than 80% of your predisability covered pay, referred to as "salary" in the Benefits section of Workday, as a result of your disability. To qualify for LTD benefits, you must be receiving continuous appropriate care and treatment from a doctor during the LTD waiting period. For more information, see the definitions of "Appropriate care and treatment" on page 12-15 and "Doctor" on page 12-15.

Generally, periods of continuous and partial disability separated by a return-to-work period of 30 days or less are added together for purposes of determining the 26-week LTD waiting period. Only the days you are disabled will count toward your waiting period. However, if you are released to return to work and more than 30 days have passed before you become disabled again, you will have to begin a new waiting period.

Premiums

If you have enrolled for Optional LTD coverage, you must continue to pay your monthly premium during the LTD waiting period and until your claim for LTD benefits is approved. After LTD benefits begin, your monthly premiums for Optional LTD coverage stop and any premiums you paid for the time after the LTD waiting period will be refunded to you. If you don't continue paying premiums during the LTD waiting period and until your claim for LTD benefits is approved, your Optional LTD coverage will terminate.

Qualifying for benefits

To qualify for LTD benefits, you must:

- Be covered by the LTD Plan on the initial date of your disability.
- Be disabled as defined by the LTD Plan for more than 26 weeks.
- Continue to pay premiums for Optional LTD coverage during the LTD waiting period and until your claim for LTD benefits is approved.
- Receive approval for LTD benefits by Lincoln.
  - Receive appropriate care and treatment by a doctor on a continuous basis. For more information, see the definition of "Appropriate care and treatment" on page 12-15.
  - Provide proof that you are disabled under the terms of the LTD Plan. For more information, see the definition of "Proof of your disability" on page 12-16.

Note: All LTD benefits are subject to the limitations and exclusions described in this SPD. Refer to the "Limitations and exclusions" section starting on page 12-10 for more information.

Definition of disability

"Disabled" or "disability" means that, due to sickness (including a mental illness), pregnancy, or accidental injury, both of the following apply:

- During your LTD waiting period and the next 24-month period, you are unable to perform the material and substantial duties of your own occupation for any employer in your local economy. (For more information, see the definitions of "Own occupation" on page 12-16 and "Local economy" on page 12-16.)
- After this 24-month period, you are unable to perform the material and substantial duties of any occupation for which you are reasonably qualified, taking into account your training, education, experience, and predisability pay for any employer.

Definition of partial disability

"Partial disability" or "partially disabled" means that, as a result of injury or sickness, you are able to do either of the following:

- Perform one or more, but not all, of the material and substantial duties of your own occupation or any occupation on a fixed term basis.
- Perform all of the material and substantial duties of your own occupation or any occupation on a fixed term basis.

To be considered partially disabled, you must earn between 20% and 80% of your covered pay, referred to as "salary" in the Benefits section of Workday. Eligibility for partial disability benefits will be based on the number of days each month for the period in question and the amount actually paid while on the reduced work schedule.

(See the definition of "Any occupation" on page 12-15.)

Your loss of pay must be a direct result of your sickness, pregnancy, or accidental injury. Economic factors, including but not limited to recession, job obsolescence, pay cuts, and job sharing, will not be considered in determining whether you meet the loss of earnings test. If you are an employee whose occupation requires a license, loss of your license for any reason does not, in itself, constitute a disability.

Preexisting conditions

The LTD Plan does not pay benefits for a disability that was contributed to, was caused by, or resulted from a preexisting condition. This is sometimes referred to as the "preexisting condition exclusion." You have a preexisting condition if both of the following are true:

- You received medical treatment, consultation, care, or services; took prescription medications; or had medications prescribed during the three months just before your effective date of LTD coverage.
- The disability begins in the first 12 months after your effective date of LTD coverage, and you have been treated for the disability during the three months before the effective date.

However, even though your condition meets the definition of a preexisting condition under the LTD Plan, you may be eligible for LTD benefits if you were previously covered under the LTD Plan of a company acquired by Wells Fargo (a "prior LTD plan").

If you were covered by a prior LTD plan on the day immediately before the date your coverage under the Wells Fargo LTD Plan became effective, your "effective date" for purposes of the preexisting condition exclusion described above will be the effective date of your coverage under the prior LTD plan. This means that if your continuous coverage under the prior LTD plan and this LTD Plan is more than 12 months as of your initial date of disability, you will not be subject to the preexisting condition exclusion. If approved, your LTD benefit will be limited to the lesser of the benefit amounts of your prior LTD plan and your current Basic LTD coverage, Optional LTD coverage, or both.

Recurrent disabilities

If you are receiving LTD benefits, recover from your disability, and then have a recurrent disability due to the same or related condition, Lincoln will treat your disability as part of your prior claim, and you will not have to complete another LTD waiting period, if:

- You were continuously covered under the LTD Plan for the period between your prior claim and your recurrent disability.
- Your recurrent disability occurs within six months of the end of your prior claim.

Your recurrent disability will be subject to the same terms of the LTD Plan as your prior claim, including the covered pay, referred to as "salary" in the Benefits section of Workday, used to determine the LTD benefit that was paid to you as a result of the prior claim.

After six months

Any disability that recurs after six months from the date your prior claim ended will be treated as a new claim and will be subject to all of the provisions of the LTD Plan, including a new LTD waiting period.

LTD Plan benefits

Covered pay

Your LTD benefit is based on your covered pay, referred to as "salary" in the Benefits section of Workday, in effect on the day before the initial date of your disability. Your covered pay is determined by the job classification code (job class code) for your position in Workday. Covered pay is converted from an annual amount (not exceeding $500,000 per year) to a monthly amount, subject to the exceptions noted below. To view your LTD covered pay, log into Workday and go to View Profile, then choose Actions, then choose Benefits, and View LTD Covered Pay under Benefits Annual Rate.

Job class code 2

Most positions within Wells Fargo are salary or hourly paid, job class code 2. For job class code 2 positions, covered pay is defined as your annual base salary plus eligible incentive compensation paid in the prior calendar year. Disability benefits are based on your covered pay on the day before your date of disability (see the date of disability definition in the "LTD waiting period" section on page 12-5).

Annual base salary

- Is your annual, monthly, or hourly* rate of pay indicated in Workday, with monthly and hourly pay annualized for the purpose of determining your covered pay.
- Does not include some forms of compensation such as overtime pay, shift differentials, incentives, bonuses (including but not limited to hiring, incentive, and retention bonuses), commissions, noncash awards, and perquisites such as parking or auto allowance or commute subsidies, if applicable.

* Your standard hours are the hours that you're expected to work each week, as maintained in Workday and are not the same as scheduled hours. Overtime pay and shift differential are excluded.

Eligible certified incentive compensation

Includes commissions, bonuses, and other earnings indicated in Workday as eligible incentive compensation.

Job class codes 1 and 5

If the Wells Fargo Rewards and Performance Management team assigns your position a Variable Incentive Compensation (VIC) pay category or a Mortgage Consultant Participant pay category, LTD coverage defines covered pay, referred to as "salary" in the Benefits section of Workday, as your benefits base indicated in Workday, based on the most recent quarterly earnings calculation, up to a maximum of $500,000. Generally, quarterly calculations are completed sometime in the first several days of each quarter. The amount of covered pay is updated on the day of the calculation. These positions are assigned job class code 5 or job class code 1 in Workday. Benefits base is calculated quarterly, and earnings are annualized based on base salary and incentives, incentive bonuses, and commissions paid in the last 12 months, divided by the number of months with earnings greater than $0, with a minimum

annual benefits base of $20,000 and a maximum annual benefits base of $500,000. Benefits base does not include some forms of compensation such as overtime pay, shift differentials, hiring and retention bonuses, noncash awards, and perquisites (such as parking or auto allowance or commute subsidies).

VIC applies to jobs with a pay structure designed to deliver 40% or more of expected total cash through incentives that are paid primarily on a monthly or quarterly basis. Assignment of jobs to VIC (job class code 5 in Workday) requires approval from Wells Fargo Rewards and Performance Management.

Benefit amount

LTD benefits are based on your covered pay, referred to as "salary" in the Benefits section of Workday, in effect on the day before the initial date of disability. If you are eligible for Basic LTD coverage, your gross monthly LTD benefit is 50% of your monthly covered pay up to a maximum benefit amount of $20,833 per month.

If you are enrolled for Optional LTD coverage, your gross monthly LTD benefit is generally 65%. Optional LTD coverage provides an additional 15% of your covered pay. Your total combined gross benefit will be 65% of your covered pay up to a maximum benefit amount of $27,083 per month (see the "Covered pay" section on page 12-6). Lincoln will calculate your monthly LTD benefit. For more information, see the "Deductible sources of income" section on this page.

The minimum monthly LTD benefit is 10% of your gross LTD benefit or $100, whichever is greater. The minimum monthly benefits will not apply if you are in an overpayment situation or are receiving income from employment (unless the income is from your participation in an approved rehabilitation program or an approved fixed term return-to-work program). For more information, see the "Recovering LTD benefit overpayments" section on page 12-12 and the "If you are disabled and working" section starting on page 12-9.

Deductible sources of income

Your gross LTD benefit will be automatically reduced by the amount of income you are eligible to receive from other sources, including but not limited to:

- Social Security benefits (including disability, retirement, and dependents' benefits but excluding survivor benefits)
- Earnings from any form of employment
- Railroad Retirement Act
- Workers' Compensation benefits attributed to lost income, including a settlement awarded to you
- Automobile or other accident wage replacement income
- Any state or public employee retirement or disability plan
- Statutory benefits, including state disability benefits
- Any other group plan providing total disability benefits sponsored by or contributed to by Wells Fargo
- Benefits for disability, retirement, or both that you receive under a retirement plan, to the extent that such benefits are attributable to employer contributions, excluding distributions from the Wells Fargo & Company 401(k) Plan, the Wells Fargo Cash Balance Plan, and Wells Fargo nonqualified plans of deferred compensation
- Third-party recovery for loss of income by judgment, settlement, or otherwise, including recovery amounts you may receive from future earnings
- Unemployment insurance laws or programs
- Maritime maintenance and cure
- Occupational disease laws
- Any income received for disability under a government compulsory benefit or program that provides for loss of time from your job due to your disability, whether such payment is made directly by the plan or program or through a third party (including but not limited to Social Security disability, retirement, and dependent benefits, but excluding survivor benefits)

If you receive deductible sources of income in a lump sum instead of in monthly payments, you must provide Lincoln with satisfactory proof of the breakdown of:

- The amount attributable to lost income
- The time period for which the lump sum is applicable

You must provide information requested by Lincoln on any deductible sources of income within 10 business days from the date of the award. If this information is not provided, Lincoln may reduce your LTD benefit by an amount equal to the LTD benefit each month until the lump sum has been exhausted. However, if Lincoln is given proof of the time period and amount attributable to lost income, Lincoln will make a retroactive adjustment.

Subrogation and reimbursement

When Lincoln has paid LTD benefits in excess of $5,000 to you, Lincoln will be subrogated to all rights of recovery that you have against a third party. Lincoln may require an assignment from you to recover the extent of Lincoln's payment.

Lincoln's subrogation rights will be valid only if you are fully compensated for your loss.

Lincoln's subrogation rights are subject to subtraction for actual monies paid to account for the pro rata share of your costs, disbursements, reasonable attorney's fees, and other expenses incurred in obtaining the recovery from another source unless Lincoln is separately represented by an attorney.

If Lincoln is separately represented by an attorney, Lincoln and you, along with the attorneys may enter into an agreement regarding allocation of your costs, disbursements, reasonable attorney fees, and other expenses. If Lincoln and you cannot reach agreement on allocation, Lincoln and you must submit the matter to binding arbitration.

Nothing in this section shall limit Lincoln's right to recovery from another source which may otherwise exist in law. For purposes of this section, full recovery does not include payments made by Lincoln to or for your benefit.

Benefit payment

LTD benefits will begin to accrue on the date following the day you complete the LTD waiting period, subject to claim approval. When Lincoln determines that you are disabled under the LTD Plan, benefits will be paid monthly following completion of your LTD waiting period and benefit approval by Lincoln. LTD benefits will be paid on a monthly basis thereafter. Generally, your LTD benefit payment will be sent to your home address unless you request that your payment be deposited directly in your bank account.

LTD benefit payments are based on the number of days you are disabled during each one-month period.

Taxes on benefits

Basic LTD benefits you may be eligible to receive are considered to be taxable income. If you elected Optional LTD coverage, the premiums are paid with after-tax dollars; therefore, the Optional LTD benefits are generally not taxable income.

You may direct Lincoln to withhold federal and state taxes from your LTD benefits. If no taxes are withheld, or if the amount withheld is not enough to cover the actual taxes due, you may be required to pay additional taxes. Consult a tax advisor for tax information related to your LTD benefits.

When benefits end

Your LTD benefits will stop and your claim will end on the earliest of the following:

- The end of the maximum benefit period (see the "Maximum long-term disability benefit period" table on this page).
- The end of the period specified for particular conditions. For more information, see the "Limitations and exclusions" section starting on page 12-10.
- The day Lincoln determines that you are no longer disabled as defined by the LTD Plan.
- The day of your death.
- The date you stop or refuse to participate in an approved rehabilitation program. For more information, see the "If you are disabled and working" section starting on page 12-9.
- The day you fail to be examined or evaluated at regular intervals by your treating providers or to attend a medical examination requested by Lincoln.
- The day you fail to cooperate in the administration of your LTD claim.
- The day you are able to work in your own occupation on a part-time basis and you choose not to (see the "Own occupation" definition on page 12-16).
- The day your partial disability earnings exceed 80% of your covered pay (referred to as Salary in the Benefits section of Workday) for three consecutive months.
- The day you fail to provide Lincoln with any of the following pieces of information:
  - Proof of your disability, which may include but is not limited to a completed Attending Physician's Statement, medical records, test results, mental health records, prescription records, and any other medical information that may be needed to evaluate your claim
  - Evidence of continuing disability
  - Proof that you are under the appropriate care and treatment of a doctor throughout your disability
  - Information about deductible sources of income during your disability
  - Any other material information related to your disability that may be requested by Lincoln

Maximum long-term disability benefit period

If you are disabled when you are	Your maximum LTD benefit period is the greater of the duration shown below, or your normal retirement age as defined by the Social Security Administration on the date your disability starts
Under 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Survivor benefit

If you die while receiving LTD benefits, the LTD Plan pays your eligible survivor a lump sum in an amount equal to five times your net monthly LTD benefit. (Lincoln will first reduce the survivor benefit by any overpayment that may exist on your claim.)

To qualify for a survivor benefit, the following conditions must be met:

- You completed the LTD waiting period.

- You were eligible to receive a monthly LTD benefit at the time of your death.
- You have an eligible survivor.
- Proof of your death is provided to Lincoln.
- The person making the claim is an "eligible survivor," which means the first of the following who survives you:
  1. Your surviving spouse or domestic partner*
  2. Your surviving unmarried children under age 25, in equal shares
  3. The surviving unmarried children of your spouse or domestic partner under age 25, in equal shares
  4. Your estate

* See the "Definitions relating to marital status" section on this page for more information.

Payment to a minor child may be made to an adult who submits proof satisfactory to Lincoln that the adult has assumed custody and support of the child.

Definitions relating to marital status

For payment of a benefit if there are no surviving or designated beneficiaries, the following terms have the meanings assigned to them below:

- "Spouse" means the person to whom you are legally married on your date of death under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, or the person who was your current common-law spouse on your date of death in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages.
- "Domestic partner" means a person of the same or opposite gender who is not your spouse as defined above, that meets at least one of the following criteria on your date of death:
  - You and the person are joined in a civil union (or other similar formal relationship) on your date of death that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the union was created but is not denominated or recognized as a marriage under the laws of that state or country.
  - You and the person share a domestic partnership (or other similar formal relationship) on your date of death that is registered by a city, county, state, or country but is not denominated or recognized as a marriage under the laws of that city, county, state, or country.
  - You and the person both meet all of the following requirements:
    i. Shared a single, intimate, committed relationship of mutual caring as of your date of death and intended to remain in the relationship indefinitely.
    ii. You resided together in the same residence and lived in a spouse-like relationship prior to your date of death.
    iii. You are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which you reside.
    iv. Neither of you was married to another person under either federal, state, or common law, and neither is a member of another domestic partnership.
    v. You were both mentally competent to consent or contract.
    vi. You were both at least 18 years old.
    vii. You were financially interdependent, jointly responsible for each other's basic living expenses, and if asked, your partner is able to provide documentation for three of the following being in effect as of your date of death:
      A. Joint ownership of real property or a common leasehold interest in real property
      B. Common ownership of an automobile
      C. Joint bank or credit accounts
      D. A will that designates the other as primary beneficiary
      E. A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other
      F. Designation of one partner as holding power of attorney for health care decisions for the other

If you are disabled and working

Your monthly LTD benefit will be reduced by any deductible sources of income (see the "Deductible sources of income" section on page 12-7), including your wages while working under an approved rehabilitation program or an approved fixed term return-to-work program (referred to as a "reduced work schedule"). Your combined LTD benefit and wages will never exceed 100% of your predisability covered pay, referred to as "salary" in the Benefits section of Workday.

During the first 12 months following your LTD waiting period, your LTD benefit will only be reduced if your LTD benefit and your earnings exceed 100% of your predisability covered pay. If the combined total is more than 100% of your predisability covered pay, the monthly LTD benefit will be reduced by the excess amount.

After the 12-month period described above, your monthly LTD benefit will be reduced by 50% of your earnings from working while disabled. Your monthly LTD benefit will be further reduced if the total amount you receive from the above sources and the deductible sources exceeds 100% of your predisability covered pay. That portion of the total amount you receive that exceeds 100% of your predisability covered pay will reduce your monthly LTD benefit (see the "Covered pay" section on page 12-6).

Eligibility for partial disability benefits will be based on the actual number of days each month and the total paid amount from "Deductible sources of income" for the period in question.

Rehabilitation program

Effective rehabilitation can often result in returning you to productive employment. A rehabilitation program means:

- Returning to active employment on either a fixed term or full-time basis in an attempt to enable you to resume gainful employment or service in an occupation for which you are reasonably qualified, taking into account your training, education, experience, and past earnings.
- Participating in vocational training or physical therapy. This must be deemed by Lincoln's rehabilitation coordinators to be appropriate.

Developing a rehabilitation program is a team effort that involves you, Wells Fargo, your doctor, and Lincoln's rehabilitation professionals. If you choose not to participate in a rehabilitation program that Lincoln recommends, your LTD benefits will terminate.

Family care expense benefit

During the first 24 months following the LTD waiting period, you may be eligible for a family care expense benefit. If you are receiving LTD benefits and you work or participate in an approved rehabilitation program or reduced work schedule, you will be reimbursed for eligible family care expenses you incur with respect to each eligible family member.

An eligible family member is a person who is living with you as part of your household and who is chiefly dependent on you for support.

Eligible family care expenses are those monthly expenses incurred by you in order for you to participate in an approved rehabilitation program, up to $325 per month for each eligible family member, to provide:

- Child care for an eligible family member under the age of 13. (Child care must be provided by a licensed child care facility or other qualified child care provider.)
- Care for an eligible family member who, as a result of a mental or physical impairment, is incapable of caring for himself or herself.

Family care expenses provided by a member of your immediate family or someone living in your residence are not eligible for reimbursement.

Eligible family care expenses do not include expenses for which you are eligible for reimbursement under any other group plan or from any other source. You must provide proof to Lincoln that you incurred such charges and that the eligible family member is incapable of caring for himself or herself and is chiefly dependent on you for support. The proof must be satisfactory to Lincoln.

Limitations and exclusions

Limitations for particular conditions

Mental illness

If you are disabled by a mental illness (see the definition of "Mental illness" on page 12-16), the LTD Plan generally pays a maximum of 24 monthly LTD benefit payments in your lifetime unless you are disabled due to:

- Schizophrenia
- Dementia
- Organic brain disease
- Bipolar disorder

If you are confined in a hospital or institution due to a mental illness at the end of 24 monthly LTD benefit payments, LTD benefits will continue until the confinement ends. If you are not confined to a hospital or institution, but are fully participating in an extended treatment plan for the condition that caused the disability, LTD benefits will be extended for 12 months. For more information, see the definition of "Mental illness" on page 12-16.

However, in no event will monthly LTD benefits be payable longer than the maximum LTD benefit period.

Alcohol, drug, or substance abuse or dependency

If you are disabled due to alcohol, drug, or substance abuse or dependency, monthly LTD benefits are limited to 24 monthly LTD benefits during your lifetime. If you are confined in a hospital or institution due to alcohol, drug, or substance abuse or dependency, at the end of 24 monthly LTD benefit payments, LTD benefits will continue until the confinement ends. You must also be concurrently participating in an available rehabilitation program recommended by a doctor. For more information, see the "Other LTD definitions" section on page 12-15 and the "Rehabilitation program" section on this page. In no event will monthly LTD benefits be paid beyond the date that any of the following occur:

- The maximum LTD benefit period has been completed (see the "Maximum long-term disability benefit period" table on page 12-8)
- 24 monthly LTD benefit payments have been made subject to the exception noted above for hospital confinement
- You are no longer participating in the rehabilitation program
- You refuse to participate in an available rehabilitation program
- You complete the rehabilitation program

Exclusions

The LTD Plan does not cover any disability that Lincoln determines has contributed to, or was caused by or results from:

- War, declared or undeclared, or any act of war.
- Active participation in a riot.
- The commission of or attempted commission of a felony.
- A preexisting condition. (For more information, see the "Preexisting conditions" section on page 12-6.)

Coverage when you're not working

Leaves of absence

Eligibility for LTD coverage continues during certain types of leaves of absence, including but not limited to:

- Medical Leave
- Workers' Compensation Leave
- Family Leave
- Paid Administrative Leave
- Parental Leave
- Critical Caregiving Leave
- Job-Protected Paid Leave

For your Optional LTD coverage to continue, you must continue to pay the monthly premiums during the LTD waiting period and until your claim for LTD benefits is approved.

For more information, see "Appendix D: Leaves of Absence and Your Benefits."

If you discontinue paying premiums, your Optional LTD coverage will stop and you will be subject to the preexisting condition exclusion should you enroll for Optional LTD coverage in the future. However, your Basic LTD coverage will continue for as long as you continue to satisfy the eligibility requirements of the LTD Plan. Your coverage and monthly premiums for Optional LTD coverage (if you were enrolled in it) will resume if you return to work in a regular or fixed term position. If you don't want coverage to resume automatically, you must notify Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, as soon as possible following your return to work.

Eligibility for Basic and Optional LTD coverage ends when the following types of leaves of absence begin:

- Personal Leave
- Job Search Leave
- Preferential Hiring Leave
- Unpaid Administrative Leave
- Military Leave
- Job-Protected Unpaid Leave

If you begin severance benefits under Wells Fargo & Company Severance Plan on or after 1/1/2022, your coverage for long-term disability will end.

This means that if you become disabled during one of these leaves, you will not be eligible for LTD benefits. But if your initial date of disability occurs before going on one of these leaves, you may be eligible for LTD benefits subject to the terms of the LTD Plan (see the date of disability definition in the "LTD waiting period" section on page 12-5).

Return to work in six months or less for employees on an approved leave of absence

If you return to work within six months or less of the first day of a Personal, unpaid Administrative, Military, Salary Continuation Leave (prior to 1/1/2022), Job Search, or Preferential Hiring, your LTD coverage will be automatically reinstated at the same level of coverage you had before your leave of absence and you will not be subject to a new LTD preexisting condition exclusion.

If you don't want coverage to resume automatically, you must notify Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, as soon as possible following your return to work.

Return to work after six months for employees on an approved leave of absence

If you return to work after six months from the first day of a Personal, unpaid Administrative, Job Search, Salary Continuation Leave (prior to 1/1/2022), or Preferential Hiring, you can enroll in the Optional LTD in Workday by going to Change Benefits and selecting Insurance Election Changes within 60 days from the date you return to your regularly scheduled work hours. Evidence Of Insurability will apply.

If you return to work after six months from the first day of a Military leave, you can enroll in the Optional LTD in Workday by going to Change Benefits and selecting Insurance Election Changes within 60 days from the date you return to your regularly scheduled work hours. Coverage for optional LTD will be effective upon your reemployment.

Note: If you did not have optional long-term disability coverage before your leave began and want to elect it upon your reemployment, see the "Late enrollment" on page 12-4 for more information.

Claims and appeals

If you are disabled for more than 18 weeks and your doctor believes your disability will be longer than 26 weeks, you will receive instructions from Lincoln for filing an LTD claim. If you have been disabled for 18 weeks or more and you have not received instructions, call Lincoln at 1-866-213-2937. If it appears likely that you will continue to be disabled, file your LTD claim early to help avoid a gap in benefits.

Note: You may also become eligible for Social Security disability benefits if your disability continues for five months or more.

For more information, please see the "Filing a claim for Social Security disability benefits" section on this page.

Filing an LTD claim

After you receive the necessary forms for filing a long-term disability claim, complete and return them to Lincoln as instructed. To receive LTD benefits, you must provide Lincoln all of the following documents:

- Proof of your disability, which may include but is not limited to a completed Attending Physician Statement, medical records, test results, mental health records, prescription records, and any other information needed in the evaluation of your claim
- Evidence of continuing disability
- Proof that you are under the appropriate care and treatment of a doctor throughout your disability
- Information about deductible sources of income
- Any other material information related to your disability that Lincoln requests

In addition, you will be required to provide signed authorization for Lincoln to obtain and release your financial and medical information.

Claims filing deadline

The deadline for filing an LTD claim is 90 days from the LTD benefit begin date. No LTD benefits will be payable for claims submitted more than 90 days from the LTD benefit begin date. The LTD benefit begin date is the date of disability after you satisfy the waiting period (see the date of disability definition in the "LTD waiting period" section on page 12-5).

However, you can request that LTD benefits be paid for late claims if you can show both of the following:

- It was not reasonably possible to give written proof of your disability during the one-year period (the one-year waiting period is defined as one year from the date of disability).
- Proof of your disability, which may include but is not limited to a completed Attending Physician Statement, medical records, test results, mental health records, prescription records, and any other information needed in the evaluation of your claim, satisfactory to Lincoln was provided as soon as was reasonably possible.

Filing a claim for Social Security disability benefits

If it appears likely that you will continue to be disabled, contact your local Social Security Administration office for information about filing a claim for Social Security disability benefits. You may also contact Lincoln if you have any questions or would like assistance filing for Social Security disability benefits.

Your spouse and children may also be eligible to receive Social Security disability benefits due to your own disability.

Recovering LTD benefit overpayments

Lincoln has the right to recover from you any amount that it determines to be an overpayment. You are obligated to refund to Lincoln any such amount.

When you apply for LTD benefits, you will be required to sign a reimbursement agreement indicating that you agree to repay all overpayments and authorizing Lincoln to obtain any information relating to other income.

Lincoln may recover an overpayment by:

- Reducing or offsetting against any future LTD benefits payable to you or your survivors.
- Stopping future LTD benefit payments, including minimum LTD benefit payments that would otherwise be due under the LTD Plan. In such cases, LTD benefit payments may continue when the overpayment has been recovered.
- Demanding an immediate refund of the overpayment from you; you have the right to appeal any overpayment recovery.

LTD claim determinations, determination extension, and requests for additional information

After you submit a claim for LTD benefits to Lincoln, it will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim, except for situations requiring an extension of time because of matters beyond the control of the LTD Plan. In such cases, Lincoln may have up to two additional extensions of 30 days each to provide you such notification.

If Lincoln needs an extension, it will notify you before the expiration of the initial 45-day period (or before the expiration of the first 30-day extension period, if a second 30-day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of Lincoln's notice requesting further information and an extension until Lincoln receives the requested information does not count toward the time period Lincoln is allowed to notify you of its claims decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from Lincoln.

Content of the claim determination

As noted previously, you will receive notice of the claim determination. An adverse benefit determination is a denial of your claim in whole or in part. Adverse benefit determinations will contain a complete discussion on why the claim was denied. If you receive an adverse benefit determination, the notice will provide the following information:

- The specific reason or reasons for the adverse determination.
- Reference to the specific LTD Plan provisions on which the determination is based.

- If the claim is denied because Lincoln did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.
- If an internal rule, protocol, guideline, or other criterion was relied upon to make the determination, the decision will state the internal rule, protocol, guideline, or other criterion or indicate that a copy of such rule, protocol, guideline, or other criterion will be provided free of charge to you upon request.
- If the adverse determination is based on medical necessity, experimental treatment, or similar exclusion or limit, you will receive an explanation of scientific or clinical judgment for the determination, applying the terms of the LTD Plan to the claimant's medical circumstances, or a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request.
- An explanation of the basis for disagreeing (or not) with any of the following information:
  - The views presented by the claimant of treating health care professionals or vocational professionals who evaluated you
  - The views of the medical or vocational experts whose advice was obtained in connection with the decision, whether or not relied upon
  - A Social Security disability benefit determination presented by you
- A description of the LTD Plan's claim appeal review procedures (including the time limits applicable to such procedures) and a statement regarding your right to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended (ERISA) Section 502(a) following an adverse benefit determination on appeal.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
- Any additional information required under applicable law.

For additional information on filing an appeal under the LTD Plan, see the "Filing an appeal" section on this page.

Filing an appeal

If Lincoln denies your LTD claim in whole or in part, you believe you should be entitled to a different amount of LTD benefits, or you disagree with any determination that has been made reflecting your benefits under the LTD Plan, you (or your authorized representative) may appeal the decision. You (or your authorized representative) must file your appeal in writing within 180 days of the date you receive Lincoln's written adverse benefit determination of your claim, regardless of any discussions or consultations about the claim. The LTD Plan has one level of appeal, which is reviewed by Lincoln. You or your duly authorized representative must sign your appeal request. It should be sent to Lincoln by U.S. mail to the following address:

Lincoln Financial Group
Attn: [insert your assigned case manager's name]
Disability Claims
PO Box 2578
Omaha, NE 68172-9688

The address for filing an appeal is also noted in Lincoln's adverse benefit determination letter.

Your appeal must be submitted in writing to Lincoln and must include at least the following information:

- Your name
- Your claim number
- Name of the plan (that is, the Wells Fargo & Company Long-Term Disability Plan)
- Reference to the initial determination
- An explanation of why you are appealing the initial determination

As part of your appeal, you may submit any additional written comments, documents (including additional medical information), records, or other information relating to your appeal that supports your request for benefits. Upon your written request, Lincoln will provide you free of charge with copies of documents, records, and other information relevant to your initial claim. A request for this information does not, however, extend the time frame you have to file your appeal.

The appeal process is your opportunity to present documentation and evidence to show that your claim for benefits is covered and payable under the LTD Plan. However, the review process does not permit you, your beneficiary, or your authorized representative to appear in person before, or meet with, anyone from Lincoln. It is your responsibility to submit any information or documentation that you wish to have considered for the appeal review within the required time frame. Please note that Lincoln does not reimburse fees that may be associated with filing the appeal or with your obtaining information you wish to have reviewed in support of your appeal.

After Lincoln receives your written timely filed appeal request, it will conduct a full and fair review of your claim. The reviewer will look at the claim anew and no deference will be given to the prior denial. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination of your claim.

In addition, the person who will review your appeal will not be the same person who reviewed your claim or a subordinate of the person who made the initial decision to deny your claim (in whole or in part). If the initial denial is based in whole or in part on a medical judgment, the reviewer will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination.

Note: It is very important that you submit all of the information you want reviewed when your appeal is filed. The date the appeal is filed is the date it is received by the claims administrator (Lincoln). Lincoln must make the appeal determination within the time frame stated below based on the date that you file your appeal regardless of whether you indicate more information to be forthcoming.

Lincoln will provide you, free of charge, with copies of any new or additional evidence or rationale considered, relied upon, or generated in connection with the claim appeal review as soon as possible and sufficiently in advance of the date on which the notice of final benefit determination is required to be provided to you (to give you a reasonable opportunity to respond prior to that date). After you receive the information, if you feel there is a need, you may submit additional information to Lincoln for final consideration in the appeal review process (such information must be submitted before the final determination is due). Lincoln must consider any response from you as part of its decision making process, provided it is submitted before the final determination is due.

Appeal determination

After you file your appeal for disability benefits with Lincoln, it (or its designated representative) will review your appeal and notify you of its decision to approve or deny your appeal. This notification will be mailed to you within a reasonable period of time, but no later than 45 days after Lincoln's receipt of your written request for appeal review, except for situations requiring an extension of time because of matters beyond the control of the LTD Plan. If an extension is required, Lincoln may have up to an additional 45 days to provide written notification of the final decision. If such an extension is needed, Lincoln will notify you before the expiration of the initial 45-day period, state the reason or reasons why such an extension is needed, and state when it will make its determination. You will have 45 days to provide any requested information from the date you receive the notice from Lincoln.

If Lincoln denies the claim on appeal in whole or in part (an adverse benefit determination), it will send you a final written decision. The notification of the decision will provide the following information:

- The specific reason or reasons why your appeal was denied.
- Reference to the specific LTD Plan provision or provisions on which the denial was based.
- If the appeal was denied because sufficient information was not provided, a description of the additional information needed and an explanation as to why it was needed.
- An explanation of the basis for disagreeing (or not) with any of the following information:
  - The views presented by the claimant of treating health care professionals or vocational professionals who evaluated you
  - The views of the medical or vocational experts whose advice was obtained in connection with the decision, whether or not relied upon
  - A Social Security disability benefit determination presented by you
- If an internal rule, protocol, guideline, or other criterion was relied upon to make the determination, the decision will state the internal rule, protocol, guideline, or other criterion, or indicate that a copy of such rule, protocol, guideline, or other criterion will be provided free of charge to you upon request.
- If the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of scientific or clinical judgment for the determination, applying the terms of the LTD Plan to the claimant's medical circumstances, or a statement that such explanation of the scientific or clinical judgment will be provided free of charge upon request.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
- If applicable, a description of the plan's additional claim appeal review procedures (including the time limits applicable to such procedures).
- A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.
- A description of any applicable contractual limitations period and its expiration date.
- Any additional information required under applicable law.

If you wish to receive copies of documents, records, and other information relevant to the final appeal decision, send Lincoln your written request for documents, records, and other information.

Legal action

With limited exceptions for violations of claim procedure regulations, no legal action can be filed against the plan until the LTD Plan's claims and appeals procedures have been exhausted (refer to the "Claims and appeals" section starting on page 12-11 for more information).

Any suit for benefits must be brought within three years from the date the final appeal determination was issued by Lincoln.

When coverage ends

Your eligibility to be enrolled for LTD coverage ends on the earliest of the following dates:

- The day Wells Fargo terminates the LTD Plan or the applicable coverage option under the LTD Plan*
- The day your last day of employment takes place
- The day you transfer to an ineligible employment classification or position
- The day you begin a Military Leave, Job Search Leave, Preferential Hiring Leave, unpaid Administrative Leave, or Personal Leave
- The day you stop paying for Optional LTD coverage (Optional LTD only)
- The first of the month following the day you request to drop your Optional LTD coverage (Optional LTD only)
- The day you die

If your initial date of disability occurs before your LTD coverage ends, you may be eligible for LTD benefits if your LTD claim is approved.

* For more information on Wells Fargo's ability to amend, modify, or terminate the LTD Plan at any time and for any reason, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

Other LTD definitions

Any occupation

"Any occupation" means any occupation for which you are or may become reasonably fitted by training, education, experience, age, and physical and mental capacity.

Appropriate care and treatment

"Appropriate care and treatment" means medical care and treatment that meet all of the following:

- It is generally accepted by physicians to cure, correct, limit, treat, or manage the disabling condition.
- It is received from a doctor whose license and qualifications are suitable for treating your disability.
- It is necessary to meet your basic health needs and is of demonstrable medical value.
- It is consistent in type, frequency, and duration of treatment with relevant guidelines of national medical, research, and health care coverage organizations and governmental agencies.
- It is consistent with the diagnosis of your condition.

Doctor

"Doctor" means a person (who is not related to you) who is legally licensed to practice medicine and is practicing within the terms of his or her license, including a licensed Ph.D. psychologist, or other licensed mental health practitioner who is not related to you. A licensed medical practitioner will be considered a doctor if:

- The provider is licensed to practice medicine in the jurisdiction where such services are provided.
- The care and treatment provided by the practitioner is within the scope of his or her license.
- The provider or practitioner is not related to you.

Local economy

"Local economy" means the geographic area surrounding your place of residence that, as defined by the U.S. Office of Management and Budget's listing of Metropolitan Statistical Areas, offers reasonable employment opportunities. It is an area within which it would be reasonable for you to travel to secure employment. If you move from the place you resided on the date you became disabled, Lincoln may look at both that former place of residence and your current place of residence to determine local economy.

Material and substantial duties

"Material and substantial duties" means responsibilities that you are normally required to perform at your own occupation and that cannot be reasonably eliminated or modified.

Mental illness

A "mental illness" is defined as a psychiatric or psychological condition classified as such in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, regardless of the underlying cause of the mental illness. You must be receiving appropriate care and treatment for your condition by a mental health doctor.

Own occupation

"Own occupation" means the activity that you regularly perform and that serves as your source of income on the initial date of your disability. It is not limited to the specific position you held with your employer. It may be a similar activity that could be performed with your employer or any other employer in your local economy.

Proof of your disability

"Proof of your disability" may include but is not limited to a completed Attending Physician's Statement, medical records, test results, mental health records, prescription records, and any other medical information that may be needed in the evaluation of your claim.

Chapter 13: Legal Services Plan

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Information about benefits and covered services, or to receive a list of Network Attorneys in your area	ARAG® Customer Care Center 1-800-299-2345 www.ARAGlegal.com/myinfo (access code = 16862wfc)
Information about enrollment in the Legal Services Plan	Employee Care 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711.
Information about premiums for the Legal Services Plan	HR Services & Support site

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Important Notifications and Disclosures," and "Appendix D: Leaves of Absence and Your Benefits" — constitutes the Summary Plan Description (SPD) for the Legal Services Plan that provides certain benefits for legal services as described within this chapter.

The basics

Highlights

The Legal Services Plan provides the following benefits:

- **Access to ARAG's Customer Care Specialists**, at 1-800-299-2345, who can assist you with finding an attorney and providing educational resources to assist you with your legal matter.
- **Legal representation and telephone advice from ARAG® Network Attorneys** for personal legal issues. Network Attorney fees for covered benefits are 100% paid in full unless otherwise stated. You may also call a Telephone Network Attorney for general legal advice and consultation as often as necessary for covered services, at no additional cost to you.

  Note: Attorneys who are participants in ARAG's Attorney Network are referred to as "Network Attorneys" throughout this SPD.
- **Online legal tools and educational resources.** The Legal Services Plan provides DIY Docs®, a Law Guide, Attorney Finder, identity theft resources, legal assessment tool, and a learning center.
- **The option to see an attorney outside of the ARAG Network and receive reimbursement for a portion of the fees** for covered services according to a schedule (refer to the "Covered services" section starting on page 13-6). You may choose to see any attorney not in the network (Non-Network Attorney) and file a claim for reimbursement of covered services. You can recommend an attorney for inclusion in the Network by simply calling ARAG. ARAG has discretion as to which attorneys are included in the Attorney Network.
- **Discounted state and federal personal tax return preparation.** There is a $50 cost for each tax preparation (federal or state). Tax preparation is limited to returns that include any of the following: Form 1040, 1040A or 1040EZ, Schedule A (Itemized Deductions), Schedule B (Interest and Ordinary Dividends), and Schedule D (Capital Gains and Losses). Returns with additional forms or schedules shall be prepared and billed at a rate of $60 per hour.

The Wells Fargo Legal Services Plan is classified as a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA). For more information about your rights under ERISA, see "Appendix B: Important Notifications and Disclosures."

This SPD constitutes the official plan document for the Legal Services Plan.

This SPD does not provide any guaranteed or vested rights to future benefits.

Insurer and claims administrator

The Wells Fargo Legal Services Plan is fully insured by ARAG (not Wells Fargo). Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa. ARAG has the responsibility in its sole discretion to administer and interpret the terms of the Legal Services Plan and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the Legal Services Plan.

Who's eligible

Regular and fixed term Wells Fargo employees are eligible to enroll in the Legal Services Plan. Dependent coverage is also available. Flexible employees and their dependents are not eligible. For more information about eligibility for legal services coverage, please see "Chapter 1: Eligibility, Enrollment, and More." You may not be covered under the Legal Services Plan as both an employee and as a spouse, domestic partner, or dependent child at the same time. Also, a dependent can only be covered under one employee. In the event of double coverage while you're a regular or fixed term employee, only your claim as an employee will be honored.

How to enroll

Initial enrollment

You may enroll in the Legal Services Plan during your designated enrollment period if you are one of the following:

- A newly hired regular or fixed term employee
- An employee who has had an employment classification change from a flexible to a regular or fixed term position
- A rehired regular or fixed term employee

Enroll on Workday during the designated enrollment period. Refer to the "When to enroll — when benefits take effect" section in "Chapter 1: Eligibility, Enrollment, and More" to determine your designated enrollment period.

If you enroll during your designated enrollment period, your coverage is generally effective the first of the month following one full calendar month of service in a regular or fixed term position. For more information, see the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More."

Late enrollment

If you do not enroll during your designated enrollment period, you must generally wait until the next Annual Benefits Enrollment period, unless you experience an event that would allow you to enroll outside of the initial designated enrollment period. See the "Qualified Events" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

If you enroll during Annual Benefits Enrollment, your coverage is effective the following January 1.

If you enroll due to a Qualified Event, coverage is effective the first of the month following the date of the event or the first of the month following the date you contact Employee Care, whichever is later.

Changing coverage

Once you enroll, you cannot cancel or modify your benefit election or coverage level during the plan year unless you have an applicable Qualified Event. See the "Qualified Events" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

Paying for your benefits

Employees pay the full cost for coverage. Each pay period, you pay premiums for your Legal Services Plan coverage through after-tax payroll deductions. Wells Fargo does not contribute toward payment of the premium.

The amount you pay for coverage depends on the coverage level you elect — You only or You + family.

Benefits when you are not working

You must continue paying the premiums to maintain coverage while you are on an approved leave of absence. If coverage was canceled due to nonpayment of premiums, you must generally wait until the next Annual Benefits Enrollment period to reenroll. For more information about your benefits when you are not working, please see "Appendix D: Leaves of Absence and Your Benefits."

How the Legal Services Plan works

After enrollment, you will receive a member kit, which includes a welcome letter, two member cards, and a member guide. You must be enrolled in the Legal Services Plan on the date you receive legal services to be eligible for applicable benefits. There are three ways to use the Legal Services Plan:

1. Online tools and resources
2. Legal advice and representation from Network Attorneys
3. Legal advice and representation from Non-Network Attorneys

When you are in need of an attorney, have questions about your legal plan, or need help finding resources about a legal topic, call one of ARAG's Customer Care Specialists at 1-800-299-2345. ARAG suggests that you always call and speak with a Customer Care Specialist before hiring an attorney so that they can confirm that your case is a covered service.

An ARAG Customer Care Specialist may assist in providing the following information:

- **Personal Network Attorney Search:** You will receive a list of Network Attorneys in your area who serve your legal matter.
- **CaseAssist® Confirmation:** Specialists will make sure your personal claim and coverage information is sent directly to you and the Network Attorney of your choice, so they can begin working on your case.
- **Learning Center:** You will have a wealth of resources, including tips on how to work with an attorney and an appointment preparation checklist.

Online tools and resources

Start using your online legal resources right away with the ARAG Learning Center. Sign on by completing the following steps:

1. Go to www.ARAGlegal.com/myinfo (access code = 16862wfc)
2. Click on the Member Login button.
3. The first time you log in, you will create a personal user name and password.

As a participant in the Legal Services Plan, you have access to the following online tools and resources through the ARAG Learning Center:

- **Learning Center** — Access to Guidebooks and Videos, Personal Information Organizer, and other educational resources that offer tips and tools for dealing with everyday legal issues.
- **Find an Attorney** — Search for a Network Attorney by name, city, county, or zip code and distance. ARAG suggests that you always call the ARAG Customer Care Center and speak with an ARAG Customer Care Specialist before hiring an attorney so that ARAG can confirm that your case is a covered service.

  You will also find tips on how to prepare for a visit, how to work with an attorney, and information about the network.
- **Online Resources** — Access to plan documents, including the Non-Network Attorney Claim Form and the Certificate of Insurance coverage, DIY Docs® where you can browse templates and use an interactive online tool that allows you to efficiently create legally valid documents such as Wills or Power of Attorney at your own pace, tips on ID theft, member stories, and assessment tools.

Note: These online tools and resources are provided to you by ARAG. Wells Fargo is not involved in the development, creation, maintenance, or updating of these online tools and resources. Additionally, Wells Fargo does not make any representations or warranties with respect to these online tools and resources provided by ARAG under the Legal Services Plan. Further, providing the use of these tools and resources under the Legal Services Plan is for general information purposes only and does not constitute the providing of legal advice by Wells Fargo & Company or any of its subsidiaries or affiliates. You should consult with your own attorney regarding your own individual situation.

Legal advice from Network Attorneys

Network Attorneys must meet specific requirements to become part of ARAG's Attorney Network, but are independent contractors responsible for the delivery of their own services. Wells Fargo does not certify the quality of the attorneys in the network.

Network Attorney fees are covered in full for all covered services unless otherwise stated. Refer to the "Covered services" section starting on page 13-6 for more information.

Network access

As a participant in the Legal Services Plan, you are guaranteed access to a Network Attorney within 30 miles of your home. If you find there aren't any Network Attorneys available in your local area, ARAG will locate an attorney from whom you may receive in-network benefits. To receive assistance, contact the ARAG Customer Care Center and tell the specialist your situation. (Access to attorneys who offer reduced fee services is not included in this guarantee.)

Telephone network

Many legal needs can be handled conveniently and quickly by a Network Attorney over the telephone. Telephone Network Attorneys may provide the following services over the phone:

- General legal advice
- Assistance with the preparation of the following documents:
  - Special powers of attorney and revocations
  - Child care authorizations
  - Challenge to denial of credit
  - Bad check notice
  - Promissory notes and affidavits related to your personal property
  - Bills of sale related to your personal property
- Review of documents up to four pages in length (does not include documents related to trusts or real estate property transfers)
- Follow-up correspondence and phone calls to third parties as necessary
- Standard will preparation, including:
  - Testamentary trusts for minor children
  - Specific bequests
  - Durable powers of attorney
  - Health care powers of attorney and revocations
  - Living wills and advance health care directives
- Immigration services
  - Legal advice and consultation on:
    - Immigration processes and guidelines
    - Filing and processing of applications and petitions
    - Laws and regulations governing various types of immigration benefits, including asylum, adjustment of status, business visas, and employment authorizations
    - Deportation and removal proceedings
  - Document review of any immigration forms
  - Document preparation of affidavits and powers of attorney
  - Preparation for immigration hearings

Advice provided by a Network Attorney applies only to the law as it relates to situations personally involving you in the United States. Also note that telephone legal advice and consultation do not provide ongoing advice about complex legal matters or legal matters for which you have already retained an attorney.

Network Attorneys can be reached by phone Monday through Friday from 9:00 a.m. to 5:00 p.m. local time. You can choose any of the attorneys in the ARAG Network and you may call as often as necessary, at no additional cost to you.

To speak to a Network Attorney over the phone, contact ARAG directly at 1-800-299-2345 or at the number on your identification card. When you contact ARAG's Customer Care Center, you will need to enter your unique member identification number shown on your identification card.

Local network

For matters within the jurisdiction of the United States, you can meet with a local Network Attorney over the phone or in-office. Appointments with a Network Attorney can be made by calling an attorney in ARAG's Network and identifying yourself as a member of the Wells Fargo Legal Services Plan through ARAG. You can choose any of the attorneys in the ARAG Network. As a member, you will receive a membership card that contains a personal member identification number. Please present this card or your personal ID number when working with a Network Attorney. If you see a Network Attorney, you do not need to file a claim for reimbursement; the Network Attorney does it for you.

Legal advice from Non-Network Attorneys

You also have the option to see an attorney outside of ARAG's Network, including attorneys from other countries that are representing matters outside the jurisdiction of the United States. However, coverage will only be provided for covered services up to the lesser of actual costs or the scheduled amount described in the "Covered services" table starting on page 13-6. After your office visit, simply notify ARAG within 60 days of your visit and file a claim form along with your attorney's invoice within 120 days of the date you incur the legal fee (refer to the "Claims for benefits" section starting on page 13-19). You will receive direct reimbursement in US currency, up to the maximum allowed by the Legal Services Plan.

Covered services

The Legal Services Plan covers services differently depending on whether or not you use an attorney in ARAG's Network as described in the "Covered services" table below and continuing on the following pages. When you use a Network Attorney, the attorney fees for most covered legal services are paid in full. Limits apply to benefits if you use a Non-Network Attorney.

The information provided in the tables that follow is for illustrative purposes only and is not a contract. This information is intended to provide a general review of the plan described. Please remember that only the insurance policy can give actual terms, coverages, amounts, conditions, and exclusions.

Service	Network Attorney	Non-Network Attorney
Telephone legal advice and consultation	Paid in full	No coverage
Identity theft services Identity theft services help you protect your privacy, identity, reputation, and property. Services include: • Legal Advice and Representation: You can work with an attorney in person or via telephone for legal advice and representation. Most covered legal matters — including IRS Audit Protection, IRS Collection Defense, and Debt Collection — are 100% paid in full when you work with a Network Attorney (coverage may vary by plan). • Prevention and Recovery Tools: You have access to several online tools to help you recover from and prevent identity theft. These tools include an Identity Theft Tracking Sheet, Personal Information Organizer, Identity Theft Prevention and Victim Action Guidebooks, and more. • Assisted Identity Restoration: Identity Theft Case Specialists are available to help you assess your situation and identify your objectives. They'll assist you with tracking activities and progress until the conclusion of each case.	Unlimited access to an identity theft case manager is paid in full	No coverage
Reduced fee services	At least 25% off Network Attorneys' standard hourly rate for services that are: (1) not covered, but (2) not specifically excluded from coverage. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a Network Attorney prior to the effective date of your legal insurance membership, the reduced fee benefit is not available.	No coverage

Service	Network Attorney	Non-Network Attorney
Reduced contingency fees	This service provides you access to a Network Attorney for a legal matter the Network Attorney deems to be appropriately handled through the use of a contingency fee. The Network Attorney will represent you under a contingent fee arrangement where the contingent fee will not exceed 25% of the net recovery if successfully resolved before or after trial, or will not exceed 30% of the net recovery if successfully resolved on or after an appeal. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a Network Attorney prior to the effective date of your legal insurance membership, the reduced fee benefit is not available.	No coverage
Immigration services	Network Attorneys provide a reduced rate of at least 25% off their normal rates for any representation-based immigration services. Attorneys will bill you directly.	No coverage
Tax services This service provides you with year-round access to experienced tax specialists. You can call toll-free for a one-on-one consultation whenever you have questions or need advice regarding your personal, non-business-related tax matters. Services include:		No coverage
• Tips for state or federal filing of personal taxes	Paid in full	
• Explanation of tax law changes	Paid in full	
• Research on complex personal tax matters	Paid in full	
• Advice regarding IRS Audits and notifications	Paid in full	
• Review of last year's personal tax return	Paid in full	
• Discounted state and federal personal tax return preparation	$50 for each tax preparation (federal or state). Tax preparation is limited to returns that include any of the following: Form 1040, 1040A or 1040EZ, Schedule A (Itemized Deductions), Schedule B (Interest and Ordinary Dividends), and Schedule D (Capital Gains and Losses). Returns with additional forms or schedules shall be prepared and billed at a rate of $60 per hour.	

Covered In-Office Legal Services

Service	Network Attorney	Non-Network Attorney
Name Change Legal services for an insured legal name change.	Paid in full	$240[1]
Uncontested Adoption Legal services in an uncontested adoption for an insured to become an adoptive parent. In international adoptions, where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement in addition to the benefits available in the United States.	Paid in full	$400[1]
Contested Adoption Legal services in a contested adoption for an insured to become an adoptive parent. In international adoptions, where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement in addition to the benefits available in the United States.		
• Advice, negotiations, and office work prior to trial	Paid in full	$800[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Uncontested Guardianship/Conservatorship Legal services in an uncontested guardianship/ conservatorship for an insured to appoint or be appointed as a guardian/conservator.	Paid in full	$480[1]
Contested Guardianship/Conservatorship Legal services in a contested guardianship/ conservatorship for an insured to appoint or be appointed as a guardian/conservator.		
• Advice, negotiations, and office work prior to trial	Paid in full	$720[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Small Claims Court		
• Legal services for an insured to bring a claim in Small Claims Court (or similar court of limited civil jurisdiction). This benefit does not include representation in court.	Paid in full	$320[1]
• Legal services for an insured to defend an action in Small Claims Court (or similar court of limited civil jurisdiction) including representation in court where allowed by law. The following exclusion does not apply to this benefit: Legal services deemed by ARAG to be frivolous or lacking merit, or in actions where you are the plaintiff and the amount ARAG pays for your legal services exceeds the amount in dispute, or in ARAG's belief you are not actively and reasonably pursuing resolution in your case.	Paid in full	$400[1]

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

2. Trial Indemnity Benefits are $300 per ½ day of trial time up to the stated amount.

3. Trial Indemnity Benefits are $400 per ½ day of trial time up to the stated amount.

Service	Network Attorney	Non-Network Attorney
Consumer Protection		
Legal services for an insured as a plaintiff or defendant regarding written, verbal, or implied contracts or warranties relating to consumer goods or services and/or residential contractor disputes (excluding insurance disputes).		
• Advice, negotiations, and office work prior to trial	Paid in full	$800[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Defense of Debt Collection		
Legal services for an insured as the defendant in a legal dispute related to consumer goods or services (excluding foreclosure, garnishment, mechanic's lien, and student loan debt collection).		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Mechanic's Lien		
Legal services for an insured to remove a mechanic's lien.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[1]
• Trial starting on day four (4) until completion	Paid in full	$100,000[1]
Student Loan Debt Collection		
Legal services for an insured as the defendant in a legal dispute related to your student loan.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[1]
• Trial starting on day four (4) until completion	Paid in full	$1,200[1]
Bankruptcy		
• Legal services for an insured up to and including filing of a Chapter 7 bankruptcy final report	Paid in full	$880[1]
• Legal services for an insured up to and including confirmation of a Chapter 13 bankruptcy. This benefit does not include the ongoing maintenance of a Chapter 13 repayment plan	Paid in full	$1,200[1]
• Legal services for an insured to file an amendment/modification to a Chapter 7 post-discharge or a Chapter 13 post-confirmation bankruptcy	Paid in full	$240[1]

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

2. Trial Indemnity Benefits are $300 per ½ day of trial time up to the stated amount.

3. Trial Indemnity Benefits are $400 per ½ day of trial time up to the stated amount.

Service	Network Attorney	Non-Network Attorney
Foreclosure of Primary Residence Legal services for an insured regarding written notice of foreclosure related to your primary residence.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Personal Property Protection Legal services for an insured as a plaintiff or defendant regarding contracts or obligations for the transfer of your personal property or your personal property rights.		
• Advice, negotiations, and office work prior to trial	Paid in full	$320[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Purchase of Real Estate – Primary Residence Legal services for an insured for the purchase of your primary residence for the review and preparation of documents, including contract for purchase and attendance at closing.	Paid in full	$320[1]
Sale of Real Estate – Primary Residence Legal services for an insured for the sale of your primary residence for the review and preparation of documents, including contract for purchase and attendance at closing.	Paid in full	$320[1]
Purchase/Sale of Real Estate – Secondary Residence Legal services for an insured for the purchase or sale of your secondary residence for the review and preparation of documents, including the contract for purchase or sale and attendance at closing.	Paid in full	$320[1]
Refinancing – Primary Residence Advice and review of relevant documents regarding refinancing of your primary residence.	Paid in full	$160[1]
Refinancing – Secondary Residence Advice and review of relevant documents regarding refinancing of your secondary residence.	Paid in full	$160[1]
Property Tax – Primary Residence Legal services for an insured in an administrative action brought by you to reduce the property tax assessment on your primary residence.		
• Advice, negotiations, and office work prior to trial	Paid in full	$400[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

2. Trial Indemnity Benefits are $300 per ½ day of trial time up to the stated amount.

3. Trial Indemnity Benefits are $400 per ½ day of trial time up to the stated amount.

Service	Network Attorney	Non-Network Attorney
Real Estate Disputes – Primary Residence Legal services for an insured as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase, or sale of your primary residence.		
• Advice, negotiations, and office work prior to trial	Paid in full	$1,200[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Real Estate Disputes – Secondary Residence Legal services for an insured as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase, or sale of your secondary residence.		
• Advice, negotiations, and office work prior to trial	Paid in full	$1,200[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Document Review Legal services for an insured for the review of your personal legal documents.	Paid in full	$40 per document
Document Preparation Legal services for an insured for the preparation of Deeds, Mortgages, Promissory Notes, Affidavits, Lease Contracts, Demand Letters, Installment Contracts, Bills of Sale, HIPAA Authorizations, and certification of trust.	Paid in full	$40 per document
Building Code Violations – Primary Residence Legal services for an insured in an administrative action for permit or code violations relating to the renovation or improvement of your existing primary residence.		
• Advice, negotiations, and office work prior to trial	Paid in full	$400[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Zoning and Variances – Primary Residence Legal services for an insured in an administrative action related to a zoning change, variance, or an eminent domain proceeding involving your primary residence.		
• Advice, negotiations, and office work prior to trial	Paid in full	$400[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

2. Trial Indemnity Benefits are $300 per ½ day of trial time up to the stated amount.

3. Trial Indemnity Benefits are $400 per ½ day of trial time up to the stated amount.

Service	Network Attorney	Non-Network Attorney
Easement – Primary Residence		
Legal services for an insured in an administrative action regarding an easement on your primary residence.		
• Advice, negotiations, and office work prior to trial	Paid in full	$400[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Neighbor Disputes – Primary Residence		
Legal services for an insured with a neighbor as a plaintiff or defendant in a dispute related to your primary residence, including boundary or property title disputes.		
• Advice, negotiations, and office work prior to trial	Paid in full	$720[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Neighbor Disputes – Secondary Residence		
Legal services for an insured with a neighbor as a plaintiff or defendant in a dispute related to your secondary residence, including boundary or property title disputes.		
• Advice, negotiations, and office work prior to trial	Paid in full	$720[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Tenant Matters – Primary Residence		
Legal services for an insured as a plaintiff or defendant with your landlord, as a tenant of your primary residence, including but not limited to eviction and security deposit disputes.		
• Advice, negotiations, and office work prior to trial	Paid in full	$320[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Defense of Civil Damage Claims		
Legal services for an insured in defense against civil damage claims, except claims involving the ownership or use of a motorized vehicle, claims that are covered by other insurance, or claims related to a felony charge.		
• Advice, negotiations, and office work prior to trial	Paid in full	$800[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

2. Trial Indemnity Benefits are $300 per ½ day of trial time up to the stated amount.

3. Trial Indemnity Benefits are $400 per ½ day of trial time up to the stated amount.

Service	Network Attorney	Non-Network Attorney
Internal Revenue Service (IRS) Audit Protection		
Legal services for an insured involving IRS audits related to your personal tax return where the initial written notice is received after your effective date. This benefit does not include audits related to the insured's failure to file a personal tax return or pay the taxes owed as indicated on the personal tax return that was filed.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Internal Revenue Service (IRS) Collection Defense		
Legal services for an insured in defense against collection actions by the IRS related to errors on your personal tax return where the initial written notice is received after your effective date. This benefit does not include collection actions related to the insured's failure to file a personal tax return or pay the taxes owed as indicated on the personal tax return that was filed.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
State and Local Tax Audit		
Legal services for an insured involving state or local tax authority audits related to your personal state tax return or personal local taxes where the initial written notice is received after your effective date. This benefit does not include audits related to the insured's failure to file a personal tax return or pay the taxes owed as indicated on the personal tax return that was filed.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Social Security/Veterans/Medicare/Medicaid		
Legal services for an insured in an administrative legal dispute arising out of Social Security, Veterans, Medicare, or Medicaid benefits. (The exclusion as it relates to employment matters for Veterans benefits is waived for this benefit.)		
• Advice, negotiations, and office work prior to trial	Paid in full	$400[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

2. Trial Indemnity Benefits are $300 per ½ day of trial time up to the stated amount.

3. Trial Indemnity Benefits are $400 per ½ day of trial time up to the stated amount.

Service	Network Attorney	Non-Network Attorney
Wills and Durable Powers of Attorney		
• Individual wills or spousal wills (does not include any tax planning service done in connection with the will)	Paid in full	$320 single document[1] $400 spousal documents[1]
• Codicil amendment to a will	Paid in full	$40 single document[1] $80 spousal documents[1]
• Living Will/Health Care Directive	Paid in full	$40 single document[1] $80 spousal documents[1]
• Power of Attorney/Financial Power of Attorney	Paid in full	$40 single document[1] $80 spousal documents[1]
Irrevocable Trust Legal services for an insured for the preparation of a stand-alone irrevocable trust.	Paid in full	$320 single document[1] $400 spousal documents[1]
Revocable Living Trust Legal services for an insured for the preparation of a stand-alone revocable trust.	Paid in full	$320 single document[1] $400 spousal documents[1]
Estate Administration and Estate Closing (Probate) Legal services for an insured in administering an estate where you have been named the executor.	Paid in full, up to nine hours per insured event (you are responsible for all charges billed beyond the first nine (9) hours)	$720[1]
Prenuptial Agreement Legal services for an insured for the preparation of a prenuptial or antenuptial agreement.	Paid in full	$320[1]
Protection from Domestic Violence		
• Legal services for the named insured to obtain a protective order related to domestic violence	Paid in full	$320[1]
• Legal services for an insured to obtain a protective order related to domestic violence when the opposing party is not an insured under the same Certificate	Paid in full	$320[1]
Uncontested Divorce, Legal Separation, or Annulment Legal services for the named insured in an uncontested divorce, a legal separation, or annulment of marriage.	Paid in full	$640[1]
Contested Divorce, Legal Separation, or Annulment Legal services for the named insured in a contested divorce, a legal separation, or annulment of marriage.	Paid in full up to 20 hours per insured event (you are responsible for all charges billed beyond the first 20 hours)	$1,600[1]
Alimony, Child Support, Child Custody, and Child Visitation Modification Defense Legal services for an insured for a motion brought against you to modify a final decree for child support, child custody, child visitation, or alimony. (The exclusion as it relates to post-judgment matters is not intended to exclude child custody, child visitation, child support, and alimony matters.)		
• Uncontested	Paid in full	$320[1]
• Contested	Paid in full	$640[1]

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

Service	Network Attorney	Non-Network Attorney
Alimony, Child Custody, and Child Visitation Enforcement Legal services for an insured for a motion brought by you or against you to enforce a final decree for child custody, child visitation, or alimony. (The exclusion as it relates to post-judgment matters is not intended to exclude child custody, child visitation, child support, and alimony matters.)		
• Uncontested	Paid in full	$320[1]
• Contested	Paid in full	$640[1]
Child Support Enforcement Legal services for an insured for a motion brought by you to enforce a final decree for child support. (The exclusion as it relates to post-judgment matters is not intended to exclude child support matters.)		
• Uncontested	Paid in full	$320[1]
• Contested	Paid in full	$640[1]
School Administrative Hearing Legal services for an insured in an administrative public or private formal school proceeding regarding disabilities, special education, and student policy violations.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Juvenile Court Proceedings Legal services for an insured child charged with a crime (except those involving traffic matters) when the court proceedings are held in juvenile court. If the matter is removed from juvenile court, coverage under this benefit will cease as of the date of the removal.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Parental Responsibilities Legal services for an insured in juvenile court proceedings (except those involving traffic matters) where a state has brought an action regarding your parental responsibilities for an insured child.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

2. Trial Indemnity Benefits are $300 per ½ day of trial time up to the stated amount.

3. Trial Indemnity Benefits are $400 per ½ day of trial time up to the stated amount.

Service	Network Attorney	Non-Network Attorney
Criminal Misdemeanor Defense Legal services for an insured in the defense against criminal misdemeanor charges, except those involving motorized vehicles and domestic violence charges. If the charge is escalated to a felony, coverage will cease as of the date of the escalation. If a felony charge is reduced or pled down to a misdemeanor, no coverage applies.		
• Advice, negotiations, and office work prior to trial	Paid in full	$720[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Minor Traffic Offenses – Broad (excluding Driving While Intoxicated (DWI) related) Legal services for an insured in the defense of a traffic offense, the conviction of which would not result in the suspension or revocation of your driving privileges. (Does not include DWI, being under the influence of drugs or alcohol, or any non-moving offense.)	Paid in full	$240[1]
Driving Privilege Protection (excluding Driving While Intoxicated (DWI) related) Legal services for an insured in the defense of a traffic offense where conviction of the offense will directly result in the suspension or revocation of your driving privileges. (Does not include DWI or being under the influence of drugs or alcohol.)		
• Advice, negotiations, and office work prior to trial	Paid in full	$400[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
Driving Privilege Restoration (excluding Driving While Intoxicated (DWI) related) Legal services for an insured in an administrative proceeding for the restoration of your suspended or revoked driving privileges. (Does not include DWI or being under the influence of drugs or alcohol.)	Paid in full	$240[1]
Insurance Disputes Legal services for an insured as a plaintiff or defendant relating to disputes with your insurance carrier.		
• Advice, negotiations, and office work prior to trial	Paid in full	$800[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

2. Trial Indemnity Benefits are $300 per ½ day of trial time up to the stated amount.

3. Trial Indemnity Benefits are $400 per ½ day of trial time up to the stated amount.

Service	Network Attorney	Non-Network Attorney
Defense of Garnishment Legal services for an insured in a legal dispute for a garnishment against you to collect judgment related to goods or services.		
• Advice, negotiations, and office work prior to trial	Paid in full	$480[1]
• Trial for three (3) days or less	Paid in full	$1,800[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
(Legal Services as it relates to post-judgment garnishment is covered for this benefit.)		
Restraining/Protective Order – Named Insured Legal services for the named insured to obtain a restraining/protective order.	Paid in full	$320[1]
Restraining/Protective Order – Insured Legal services for an insured to obtain a restraining/protective order when the opposing party is not an insured under the same Certificate.	Paid in full	$320[1]
Funeral Directive Legal services for the preparation of a funeral directive.	Paid in full	$40 per document
Gender Identification Change Legal services for you to legally change your gender identifier on government issued documents.	Paid in full	$240[1]
Hospital Visitation Authorization Legal services for the preparation of a hospital visitation authorization.	Paid in full	$40 per document

1. Non-Network Attorney Indemnity Benefits are up to the stated amount.

2. Trial Indemnity Benefits are $300 per ½ day of trial time up to the stated amount.

3. Trial Indemnity Benefits are $400 per ½ day of trial time up to the stated amount.

Plan exclusions and limitations

The exclusions listed below do not constitute a complete listing of excluded or limited services. If you have a question about coverage for a specified service, please contact ARAG directly.

The Legal Services Plan does not cover the following:

- An event that occurs before the effective date of coverage, including a written notice of a legal dispute that is sent or filed by an insured or received by an insured before an insured's effective date of coverage under this plan; a ticket or citation is issued before an insured's effective date of coverage under this plan; or an attorney is hired before an insured's effective date of coverage under this plan
- Legal services for matters against ARAG Insurance Company, ARAG, Wells Fargo & Company and any of its subsidiaries or affiliates, or any Wells Fargo-sponsored benefit plan, including, without limitation, any claims administrator, insurer, other service provider to such benefit plan, or a covered dependent against the interests of the covered employee under the same Certificate
- Legal services arising out of a business interest, investment interests, employment matters, employee benefits, your role as an officer or director of an organization, and patents or copyrights
- Legal services for DWI-related offenses (driving while impaired or under the influence of drugs or alcohol, or a related offense)
- Legal services in class actions, punitive damages, personal injury, malpractice, court appeals or post judgments, with the exception of post-judgment garnishment (for example, settlement agreement signed by all parties, final binding arbitration, judgment issued by a court)
- Legal services deemed by ARAG to be frivolous or lacking merit, or in actions where you are the plaintiff and the amount ARAG pays for your legal services exceeds the amount in dispute, or in ARAG's belief you are not actively and reasonably pursuing resolution in your case
- Charges above the stated limits in the "Covered services" table starting on page 13-6

When coverage ends

Coverage under the Legal Services Plan ends on the last day of the month in which one of the following events occurs:

- Your last day of employment or the last day of your severance eligibility period under the Wells Fargo & Company Severance Plan, whichever is later.[1]
- You no longer meet the eligibility requirements.
- You voluntarily make a permitted election to drop coverage. Refer to the "Changing coverage" section on page 13-14 for more information. (Exception: If you make an election to drop coverage during Annual Benefits Enrollment, that coverage ends December 31 of the year in which the Annual Benefits Enrollment election was made.)
- You die.

If you are in the middle of an issue when your coverage ends, for any reason, the matter will be completed under the plan at no additional charge. You do not need to continue coverage to complete the matter.

Coverage for your dependents ends when they no longer meet the eligibility requirements or when your coverage ends, but they may have the option of converting their policy to an individual policy. For more information about conversion coverage, contact ARAG directly at 1-800-299-2345.

Note: Upon your death, coverage for your covered dependents continues for 12 months from the date of your death and premiums are waived during this time.

Coverage under the Legal Services Plan will also end if you stop paying the required premiums or if the Legal Services Plan is discontinued or terminated regardless of any of the events noted above.[2]

1. If you are rehired by Wells Fargo as a regular or fixed term employee with a first day of reemployment during your severance eligibility period, any benefits that continued during the severance eligibility period will continue as a rehired employee. For more information, see the "Rehired employees" section in "Chapter 1: Eligibility, Enrollment, and More."

2. For information on Wells Fargo's ability to amend, modify, or terminate the Legal Services Plan, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

Continuing your coverage directly with the carrier

If you leave Wells Fargo's employment or become otherwise ineligible, you have the option to convert your coverage to an individual policy. ARAG will send enrolled employees a personalized communication about continuation of coverage within 31 days of the date your coverage ends (end of the month of your last day of employment). You may also contact ARAG directly at 1-800-299-2345 and request a Conversion Application Form. Return the completed form and any applicable payment to ARAG within 90 days from the date your coverage ends (end of the month of your last day of employment) to enroll directly with ARAG. For more information concerning your eligibility for conversion coverage, contact ARAG directly at 1-800-299-2345.

Claims and appeals

Claims for benefits

ARAG administers all claims for benefits under the Legal Services Plan. To file a claim for Non-Network Attorney services, obtain a claim form by logging in on the ARAG® website at https://araglegal.com/myinfo (access code = 16862wfc) or by contacting ARAG Customer Care at 1-800-299-2345. Submit the claim form with an itemized attorney invoice within 120 days of completion of the legal services. Claims for benefits should be sent to ARAG at the following address:

ARAG
Attention: Claims
500 Grand Ave.
Suite 100
Des Moines, IA 50309-2337

ARAG also is the claims fiduciary responsible for benefit determinations. ARAG has the responsibility in its sole discretion to administer and interpret the terms of the Legal Services Plan, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the Legal Services Plan. Its decisions on these matters are conclusive. Any interpretation or determination made pursuant to this discretionary authority shall be subject to limited judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (that is, arbitrary and capricious).

If a benefit claim, or any part of it, is denied, you or your beneficiary must be notified within 90 days after ARAG receives the claim. There may be special circumstances in which it may take more than 90 days to get a decision on a claim. If this happens, the person making the claim will be notified in writing of the reasons for the delay and the date by which a final decision can be expected. The person filing the claim will be informed about the delay before the initial 90 days have passed.

If ARAG denies all or part of your claim, you or your beneficiary will be notified in writing. This notice will include:

- Specific reasons why the claim was denied
- Specific reference to the provisions of the group policy or other relevant records or papers, and information regarding where you may see them
- Descriptions of any additional material or information that must be supplied in order to satisfy the claim requirements, along with an explanation of why such material or information is necessary
- Instructions on how to appeal for reconsideration of ARAG's decision
- A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination
- A statement that you may request copies of the documents relevant to the denial

Appealing a denied claim

If you disagree with ARAG's claim decision, you have the right to file an appeal. Your appeal must be filed in writing to ARAG within 60 days of notification of the original claim denial. When filing your appeal, you should also submit to ARAG, in writing, the claim form and any information or comments pertinent to the review that support why your claim should be paid. Submit your appeal to:

ARAG
Attention: Claims
500 Grand Ave.
Suite 100
Des Moines, IA 50309-2337

The review process does not permit you, your beneficiary, or your authorized representative to appear in person before, or meet with, ARAG. ARAG must review the claim appeal as expeditiously as possible and also must give due consideration to any information or comments submitted in writing by, or on behalf of, the claimant. ARAG will make an appeal determination within 60 days if reasonably possible.

If there are special circumstances and an appeal determination cannot be made within 60 days, ARAG will be allowed additional time, but it must reach a decision within 120 days after receipt of the appeal.

After ARAG has completed the review of the claim appeal, a written appeal determination will be issued to you or your authorized representative. It will include the specific references to the pertinent provisions of the Legal Services Plan on which the decision is based and a statement indicating your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. In addition, after ARAG has completed its final review of the claim on appeal, you will have the right to file suit in federal court in accordance with ERISA Section 502(a).

Legal action

No legal action can be made to recover expenses before you have exhausted the appeal procedures outlined in the "Claims and appeals" section starting on page 13-19. All action pertaining to a claim must be made within time limits set forth in the group policy issued by ARAG Insurance Company and applicable state law, or both. In the absence of such time limits, all action pertaining to a claim must be brought within one year after ARAG has made a final decision or, if earlier, within two years from the date the service was rendered or after the claim arose, whichever is applicable.

Agent for service of legal process

The agent for service of legal process is ARAG. All correspondence should be directed to ARAG at:

ARAG
Attn: Legal Department
500 Grand Ave.
Suite 100
Des Moines, IA 50309-2337

Chapter 14: Critical Illness Insurance Plan

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Contacts

Information about Critical Illness Insurance provisions and premiums	HR Services & Support site
Information about Critical Illness Insurance Plan enrollment	HR Services & Support site 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711
Review your Group Critical Illness Insurance Certificate of Insurance, designate and maintain your beneficiaries, and file claims	metlife.com/mybenefits
Questions about claims or appeals	Metropolitan Life Insurance Company 1-866-549-2320

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Important Notifications and Disclosures," and "Appendix D: Leaves of Absence and Your Benefits" (SPD) and the corresponding Certificate of Insurance ("certificate") issued in your state of residence when you initially enrolled — constitutes the Summary Plan Description for the Wells Fargo & Company Critical Illness Insurance Plan (the "Critical Illness Insurance Plan").

The basics

General Information

The Critical Illness Insurance Plan offers two types of coverage:

- Basic Critical Illness coverage
- Optional Critical Illness coverage

Wells Fargo pays the premium for Basic Critical Illness coverage, so all regular and fixed term employees are automatically enrolled. To participate in the Optional Critical Illness coverage option, you'll need to actively enroll and pay the applicable premium.

This SPD is a summary of provisions for the Critical Illness Insurance Plan and its underlying fully insured policy issued by Metropolitan Life Insurance Company ("MetLife") and the corresponding Certificate of Insurance ("certificate"). For further details, after your effective date you can view your state-specific certificate by signing into metlife.com/mybenefits and following the instructions to set up your online MetLife account (enter "Wells Fargo" for "Employer"); otherwise, you can view a sample certificate by accessing metlife.com/wf (due to certain state variations, there may be differences between your state-specific certificate and the sample certificate). The SPD and Group Policy Number 164933 issued by MetLife, along with any applicable certificates, policy amendments, riders, and endorsements, (collectively the "Group Policy"), constitute the official plan document for this Critical Illness Insurance Plan. If there are differences between the SPD and the Group Policy, the Group Policy governs your rights to benefits.

Generally, within two weeks of your effective date in the Critical Illness Insurance Plan, you will be able to access the state-specific certificate for your state of residence by going to metlife.com/mybenefits and following the instructions to set up your online MetLife account (enter Wells Fargo for "Employer"). If you would like a free printed copy of the state-specific certificate for your state of residence, contact MetLife.

Note: The certificate is applicable to your state of residence, as noted on your address in Workday when your initial enrollment in the plan is reported to MetLife. It is very important that you keep your address updated in Workday because certain eligibility provisions are based on your state of residence. This certificate generally remains in effect even if you move to another state. However, if you move to a state that does not allow eligibility for certain dependents, they will automatically lose coverage when your address is updated in Workday.

The Critical Illness Insurance Plan is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Insurer and claims administrator

The Critical Illness Insurance Plan is fully insured by Metropolitan Life Insurance Company (MetLife). MetLife is the named fiduciary for purposes of claims and appeals and has sole and complete discretionary authority to interpret the plan and to decide questions of fact as necessary to make benefit determinations. Wells Fargo is the plan administrator and has retained all other authority not delegated to MetLife herein.

Critical Illness Insurance Plan coverage

The Critical Illness Insurance Plan is not medical coverage and should not be considered a replacement for enrolling in medical coverage. Payments are pre-determined based on the diagnosed covered condition as detailed in the "Schedule of Insurance" section of the certificate, not based on the amount you are charged for the treatment or service. The Critical Illness Insurance Plan provides a lump-sum benefit for you, or for your eligible enrolled dependents, upon diagnosis of one of the covered critical illness conditions. See the certificate for full benefit details on the MetLife site: metlife.com/mybenefits.

Payment is made directly to you, not your doctors or healthcare providers. You have flexibility to spend the payment on anything, including medical expenses or daily living expenses. As a result, the benefits may be taxable to you as gross income.

Regular and fixed term employees are automatically enrolled in "You only" Basic Critical Illness Insurance coverage. You can elect to enroll in Optional Critical Illness Insurance coverage for yourself, and any eligible dependents you choose to cover, during your initial designated enrollment period or during Annual Benefits Enrollment.

You, or your eligible dependent, must be enrolled in the Critical Illness Insurance Plan on the date of diagnosis to receive benefits.

After you or your eligible enrolled dependent have been diagnosed with one of the eligible covered conditions, file a claim for benefits. See the "Claims" section of the certificate for claims filing information. To view the certificate, visit metlife.com/mybenefits.

If you are enrolled in the Critical Illness Insurance Plan, you agree to authorize your provider to give MetLife information about your diagnosis to determine if benefits are available under this plan. Your failure to provide this authorization or any requested information may result in denial of your claim.

Critical Illness Insurance Plan at a glance

	Basic Critical Illness Insurance Coverage	Optional Critical Illness Insurance Coverage
Benefit amount	Up to $5,000 maximum per covered condition ($25,000 lifetime maximum per covered person) **Note:** Payments may be taxable. Wells Fargo does not provide tax advice.	Up to $15,000 maximum per covered condition ($75,000 lifetime maximum per covered person)
Who pays the premium?	Wells Fargo pays the cost of basic coverage for you only.	You pay the full cost of optional coverage for you and your dependents.
MetLife policy number	0164933	
Type of ERISA plan	Welfare benefit plan	
Who's eligible	Employees on U.S. payroll who have an employment classification of: • Regular or fixed term See the "Who's eligible" section on page 14-6 for more information.	Employees on U.S. payroll who have an employment classification of: • Regular or fixed term and their eligible dependents See the "Who's eligible" section on page 14-6 for more information.
Who's not eligible	• Employees who have an employment classification of intern or flexible • Dependents	• Employees who have an employment classification of intern or flexible • Dependents who do not meet Wells Fargo dependent eligibility criteria • You, if you are enrolled in optional coverage under the Critical Illness Insurance Plan as a dependent of another employee • Your dependent, if that individual is already enrolled in optional coverage under the Critical Illness Insurance Plan as an employee or the dependent of another employee • An unborn or stillborn child
Beneficiary	If you are deceased at the time the benefit is payable, the benefit will be paid to your designated beneficiary. See the certificate for more information. To view the certificate, visit metlife.com/mybenefits.	If you are deceased at the time the benefit is payable, the benefit will be paid to your designated beneficiary. See the certificate for more information. To view the certificate, visit metlife.com/mybenefits.
Cost	Basic Critical Illness Insurance coverage is provided for eligible employees at no cost to you.	The cost for Optional Critical Illness Insurance coverage is based on the rate for the coverage level you elect: • You only • You and spouse or domestic partner • You and children • You and spouse or domestic partner and children The amount you pay for optional coverage also depends on your age (as of December 31 of the preceding year) and your smoker status (smoker or non-smoker). The amount you pay may change when your age or smoker status changes. You pay your share of the Optional Critical Illness Insurance with after-tax deductions withheld from your pay. You authorize these payroll deductions when you enroll in the Optional Critical Illness Insurance Plan.

	Basic Critical Illness Insurance Coverage	Optional Critical Illness Insurance Coverage
Coverage effective date	The later of January 1, 2021, or the first of the month after one full calendar month of service from your date of hire or employment classification change to a regular or fixed term position, provided that you are actively at work on the day coverage is scheduled to begin.	**Annual Benefits Enrollment elections** Elections you make during the Annual Benefits Enrollment period are effective the following January 1 if you are still actively at work on that date; dependents are subject to the nonconfinement clause (refer to the "Delayed effective date" section on page 14-6). If you drop your coverage during Annual Benefits Enrollment, your election to drop coverage is effective on the following January 1. **New Hires and newly eligible employee elections** Generally, the first of the month after one full calendar month of service from your date of hire or employment classification change to a regular or fixed term position, provided that you enrolled during your new hire or newly eligible enrollment period and you are actively at work on the day coverage is scheduled to begin. For more information see the: • "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More" • "Delayed effective date" section on page 14-6 to understand the actively at work requirement Dependents are subject to the nonconfinement clause (refer to the "Delayed effective date" section on page 14-6). **Changes during the year** The first of the month after you change your election to drop or decrease your level of coverage as permitted by the Plan.
Change or cancel coverage	You cannot make changes to basic coverage since you automatically receive coverage at no cost to you.	Enroll or make changes to optional coverage during the Annual Benefits Enrollment period for any reason. You may access Workday at any other time to drop or decrease your optional coverage level, but you cannot reenroll yourself or a dependent until the next Annual Benefits Enrollment period. Dependents can only be dropped mid-year if they lose eligibility. **Note:** If a covered dependent ceases to be eligible, coverage under the Plan ends for that dependent by virtue of ceasing to be a dependent; however, we rely on you to make the election change in Workday. Thus, it is your obligation to make the change in Workday as soon as possible to notify us that the dependent is no longer eligible. Failure to make this change in Workday may result in MetLife requesting that you repay any claims that are paid for the ineligible dependent or retroactively terminating your coverage if MetLife believes that you have engaged in fraud.
Coverage when you're not working during an approved leave of absence	Basic Critical Illness Insurance coverage will generally continue up to a maximum of 24 months while on an approved leave of absence.	If your Optional Critical Illness Insurance coverage was already in effect on the date your approved leave of absence starts, coverage may continue when you are not actively at work during an approved leave of absence provided that you continue to pay the premiums. See the "Benefits when you're not working" section on page 14-9.

Who's eligible

General eligibility

Regular and fixed term Wells Fargo employees and their eligible dependents as described in the "Who's eligible to enroll" section of "Chapter 1: Eligibility, Enrollment, and More" are eligible for coverage under the Critical Illness Insurance Plan. Interns and flexible employees and their dependents are not eligible for coverage.

You may not be covered under the Optional Critical Illness Insurance coverage as both an employee and a spouse or domestic partner, or as an employee and a dependent child at the same time. Also, a dependent can only be covered under one employee.

Additional eligibility rules may apply (for example, in certain states, you may be able to enroll your grandchildren). See the certificate for details at MetLife: metlife.com/mybenefits.

Audits of dependent eligibility

Refer to the "Audits of dependent eligibility" section in "Chapter 1: Enrollment, Eligibility, and More."

Fraudulent enrollment

Refer to the "Consequences of fraudulent enrollment" section in "Chapter 1: Enrollment, Eligibility, and More."

How to enroll and when coverage begins

Refer to the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the timeframe and process for enrolling during your initial designated enrollment period. After you have enrolled, coverage will begin as described in the "Coverage effective date" row in the "Critical Illness Insurance Plan at a glance" table starting on page 14-4 subject to the "Actively at work requirement" provision for employees and the "Nonconfinement clause" for dependents (see the "Delayed effective date" section on this page for more information).

If you did not enroll when you were first eligible, see the "Changing or canceling coverage" section starting on this page for information about enrolling at a later date.

Delayed effective date

Actively at work requirement

If you are not actively at work on the day coverage would start for a plan year, your Basic Critical Illness Insurance coverage and Optional Critical Illness Insurance coverage will begin when you return to being actively at work. "Actively at work" means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to travel or allows you to work. You will be deemed to be "Actively at work" during weekends or approved PTO, observed holidays, or temporary business closures if you were "Actively at work" on the last scheduled work day preceding such time off.

Nonconfinement clause

If you are enrolled in Optional Critical Illness Insurance coverage at a coverage level that covers eligible dependents, coverage will start for the dependent on the date your coverage starts, provided that the person to be covered is not confined at home under a physician's care, receiving or applying to receive disability benefits from any source, or hospitalized* because of illness or disease ("confinement"). If so, coverage will be delayed until he or she is released from such confinement (known as the "nonconfinement clause" and referred to as "medical restriction" in the certificate).

*Hospitalized for the purposes of the nonconfinement clause means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long-term care facility; or receipt of chemotherapy, radiation therapy, or dialysis regardless of where the care is administered.

Changing or canceling coverage

If you did not enroll in Optional Critical Illness Insurance during Annual Benefits Enrollment or your initial designated enrollment period, you must wait until the next Annual Benefits Enrollment period to enroll. If you enrolled in Optional Critical Illness Insurance but did not enroll your eligible dependents, you must wait until the next Annual Benefits Enrollment period to enroll your eligible dependents (with the exception for a newly eligible child, as described below). To add eligible dependents, you must already be enrolled or elect to enroll in Optional Critical Illness Insurance (provided that you are eligible).

A newly eligible child, as defined in "Chapter 1: Eligibility, Enrollment, and More," who becomes eligible while your insurance is in effect (for example, a newborn or newly-adopted child) may be automatically covered, without enrollment, through the last day of the plan year that follows the next open enrollment period (the newly eligible child will not display as covered on your Benefits Statement during this period). To continue coverage for the child, you must enroll the child at the next available opportunity during open enrollment at which point they will display on your Benefits Statement. See the certificate for more information and requirements. To view the certificate, visit metlife.com/mybenefits.

You must promptly access Workday to drop an enrolled dependent who is no longer eligible. You may otherwise drop your optional coverage at any time, but you may only reenroll or add an eligible dependent during the next Annual Benefits Enrollment period.

For the coverage effective date after making a change to your coverage election, see the "Coverage effective date" row in the "Critical Illness Insurance Plan at a glance" table starting on page 14-4.

Cost

Wells Fargo pays the full cost for your Basic Critical Illness Insurance coverage. You do not pay for any part of the Basic Critical Illness Insurance coverage.

You pay the full cost for Optional Critical Illness Insurance coverage, including any coverage for eligible enrolled dependents. Each pay period, you pay premiums for your Optional Critical Illness Insurance coverage through after-tax payroll deductions. Wells Fargo does not contribute toward payment of the premium for Optional Critical Illness Insurance coverage. You authorize these after-tax payroll deductions by enrolling in the Optional Critical Illness Insurance coverage.

The amount you pay for Optional Critical Illness Insurance coverage depends on your age (as of December 31 of the preceding year), your smoker status (smoker or non-smoker), and the coverage level you elect.

- You only
- You and spouse or domestic partner
- You and children
- You and spouse or domestic partner and children

The amount you pay will increase when your age moves to a new age range, as specified in the attained age chart on this page. For example, if you are 39 years of age on December 31, 2021, and enroll in Optional Critical Illness coverage, your premium will be based on the age 35-39 age range for 2022 payroll deductions. However, for 2023 payroll deductions, your premium will be based on the age 40-44 age range.

Attained age (as of December 31 of the preceding year)
<25
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70+

Premium rates for coverage for individuals who have not used any tobacco and/or nicotine products during the last 12 months are lower than the premium rates for tobacco and/or nicotine users. Tobacco and nicotine products include but are not limited to cigarettes, electronic cigarettes, cigars, pipes, chewing tobacco, nicotine gum, and nicotine patches.

If your tobacco-free and/or nicotine-user status changes after you enroll, you may change your tobacco-user and/or nicotine-user status at any time; however, changing status from tobacco-user and/or nicotine-user to nonuser status requires that the insured be tobacco-free and nicotine-free for at least 12 months. To change your tobacco-user and/or nicotine-user status, access Workday. The change will be effective the first of the month following the date you update your tobacco-user and/or nicotine-user status in Workday. Tobacco-user and/or nicotine-user status cannot be changed retroactively.

For example, if you enroll as a tobacco and/or nicotine nonuser but later begin to use tobacco or nicotine products, you must change your status to tobacco and/or nicotine user. Conversely, if you enroll as a tobacco and/or nicotine user and go 12 months without using any tobacco and/or nicotine products, you may change to tobacco-nonuser and/or nicotine-nonuser status. In either case, the new premium will be effective the first of the month following the date you input the change in Workday.

Taxation of Basic Critical Illness Benefits

The premiums for the Basic Critical Illness Insurance coverage are paid by Wells Fargo on a pre-tax basis. When premiums are paid for on a pre-tax basis, benefits paid may be subject to taxation as dictated by the Internal Revenue Code. The benefit payment may be taxable and is subject to applicable federal, state, local, Social Security, and Medicare taxes.

Under the Basic Critical Illness Insurance coverage, MetLife will issue a 1099-Misc to you for benefits paid under the plan that exceed $600. It is your obligation to report any taxable benefits on your applicable state and federal tax returns.

Although the full benefit is reported, portions of the benefit attributable to any expenses not covered by insurance may be excluded from income. You are responsible for determining the amount of income to report for benefits received and paying any required taxes. MetLife, Wells Fargo or its employees, the plan administrator, and the plan are not permitted to provide tax or legal advice. Consult a tax advisor or legal professional about your specific situation.

Beneficiaries

A beneficiary may be named by you to receive a benefit that becomes payable to you under this benefit that you are not alive to receive. Please refer to the claims section of the certificate for beneficiary information and what happens if you do not designate a beneficiary. To view the certificate, visit metlife.com/mybenefits.

Adding or Changing beneficiaries

You may add or change beneficiaries under the Critical Illness Insurance Plan at any time by accessing the MetLife site, at metlife.com/mybenefits, or you can call MetLife, at 1-866-549-2320 to request a beneficiary designation form. The change becomes effective on the date you updated your beneficiary on the MetLife site or the date your completed form is received by MetLife.

Critical Illness Insurance Plan benefits

The Critical Illness Insurance Plan coverage is designed to pay a benefit amount if you or your covered family member is enrolled in the Critical Illness Insurance Plan and provides proof of a diagnosis made, while coverage is in effect, for one of the covered conditions listed in the certificate.

The Plan provides Basic Critical Illness Insurance coverage for eligible employees and provides Optional Critical Illness Insurance coverage for employees and eligible dependents who are enrolled in Optional Critical Illness Insurance coverage.

Review the certificate (basic or optional) for the schedule of covered benefits and conditions and the limitations and exclusions. To view the certificate, visit metlife.com/mybenefits.

Payment of the critical illness benefits under the Plan are subject to all of the conditions, maximums, limitations, exclusions, proof requirements, definitions, and terminology stated in the Insurance Documents (defined at the beginning of this SPD), including the certificate applicable to your state of residence.

Critical Illness Insurance Plan claims and appeals

You have certain rights and obligations with respect to claims for benefits. The details surrounding those rights and obligations, including but not limited to the time period for filing claims, where to file claims, and the time period for appealing any adverse benefit determinations are generally set forth in the certificate. However, we have identified the fundamental rights and obligations of both the Plan and you with respect to claims and appeals, as prescribed by ERISA.

For purposes of this SPD, an "adverse benefit determination" means a denial, in whole or part, of any request for benefits from a benefit plan.

- You have the right to have an authorized representative file a claim for benefits on your behalf. Whether a representative is *authorized* to act on your behalf will be determined in accordance with the certificate or MetLife's reasonable procedures.
  - The plan may establish reasonable procedures for filing claims for benefits. For example, you may be required to file your claims in writing at a specified address. The specific claim filing procedures will be described in the certificate.
- If you receive an adverse benefit determination, you will receive a notice of the adverse benefit determination that contains the following information:
  - Reference to the specific plan provisions on which the denial is based;
  - A description of the information necessary to perfect your claim;
  - A description of the plan's procedures for filing an appeal of the adverse benefit determination;
  - A statement of your right to file suit under ERISA 502(a) (provided you exhaust the plan's claims and appeal procedures).
- You have the right to receive from MetLife upon request and free of charge, reasonable access to and copies of all documents and records that are "relevant" to your claim for benefits (as defined by ERISA).
- You generally may not file suit until you have exhausted the plan's internal claims and appeals process.

Named claims fiduciary

MetLife (the insurer) shall serve as the named claims fiduciary for the Critical Illness Insurance Plan and shall have sole and complete discretionary authority to determine conclusively for all parties and, in accordance with the terms of the documents or instruments governing the Critical Illness Insurance Plan, any and all questions arising from:

- Administration of the Critical Insurance Plan claims and interpretation of all provisions of the Critical Illness Insurance Plan
- Determination of all facts that are relevant to a claim for benefits
- Determination of the documents, records, and other information that is relevant to a claim for benefits
- Determination of benefits to be provided to any participant or beneficiary
- Construction of all terms of the Critical Illness Insurance policy.

Decisions by MetLife shall be conclusive and binding on all parties.

Neither the plan administrator nor Wells Fargo provides any review of claims made or pays any benefits to Critical Illness Insurance Plan participants.

Legal action

There is a period of time after which you will not be entitled to take legal action. See the certificate for more information regarding that limitation. To view the certificate, visit metlife.com/mybenefits.

Right of recovery

If, at any time, MetLife determines that benefits paid under this plan were more than the benefits due:

- You, or any other person or entity, to whom MetLife overpaid benefits have the obligation to reimburse MetLife for the amount of such overpayment
- MetLife has the right to recover the amount of such overpayment from you, any other person, or entity to whom MetLife overpaid benefits, including offsetting future benefits payable under this plan to you or such other person or entity by an amount equal to the overpayment.

This provision will not be interpreted to create a right of subrogation by MetLife.

Benefits when you're not working

When you're on an approved leave of absence, you may be able to continue Critical Illness Insurance coverage even if you are not actively working for Wells Fargo. For Basic Critical Illness Insurance, coverage may continue during your approved leave, generally up to a maximum of 24 months. You must continue paying the premiums to maintain the Optional Critical Illness Insurance Plan coverage while you are on an approved leave of absence. For more information about paying premiums while on a leave of absence, see "Appendix D: Leaves of Absence and Your Benefits". If coverage is canceled due to nonpayment of premiums while you are on an approved leave of absence, you must wait until the next Annual Benefits Enrollment period to reenroll. Coverage is effective January 1 of the year following your Annual Benefits Enrollment election, provided you are actively at work on the day coverage is scheduled to begin.

When coverage ends

Coverage under the Critical Illness Insurance Plan ends on the last day of the month in which one of the following events occurs:

- Your last day of employment or the last day of your severance eligibility period under the Wells Fargo & Company Severance Plan, whichever is later[1]
- You no longer meet the eligibility requirements
- You voluntarily make a permitted election change to drop coverage (Exception: If you make an election to drop coverage during Annual Benefits Enrollment, that coverage ends December 31 of the year in which the Annual Benefits Enrollment election was made)

In addition, if you (the employee) have received the lifetime maximum benefit payable, also known as "total benefit amount," your Basic Critical Illness Insurance coverage will end.

Optional Critical Illness Insurance coverage will also end if you stop paying the required premiums.

Coverage under the Critical Illness Insurance Plan (both basic and optional) will end when the Critical Illness Insurance Plan is discontinued or terminated regardless of any of the events noted above.[2]

1. If you are rehired by Wells Fargo as a regular or fixed term employee and your first day of reemployment occurs during your severance eligibility period, any benefits that are in effect on the day before your rehire will continue as a rehired employee. For more information, see the "Rehired employees" section in "Chapter 1: Enrollment, Eligibility, and More."
2. For information on Wells Fargo's ability to amend, modify, or terminate the Critical Illness Insurance Plan, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

If you die, coverage ends on your date of death.

Optional Critical Illness Insurance coverage for your covered dependents ends when they no longer meet the eligibility requirements. Optional Critical Illness Insurance coverage for all of your covered dependents also ends when your coverage ends.

In certain states, state insurance law may require MetLife to provide continuation of coverage when coverage ends, as set forth in the certificate.

Chapter 15: Optional Accident Insurance Plan

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Contacts

Information about Optional Accident Insurance general provisions and premiums	HR Services & Support site
Information about Optional Accident Insurance Plan enrollment	HR Services & Support site 1-877-HRWELLS (1-877-479-3557), option 2 Employee Care accepts all relay service calls, including 711
Review your Group Accident Insurance Certificate of Insurance, designate and maintain your beneficiaries, and file claims	metlife.com/mybenefits
Questions about claims or appeals	Metropolitan Life Insurance Company 1-866-549-2320

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Important Notifications and Disclosures," and "Appendix D: Leaves of Absence and Your Benefits" (SPD) and the corresponding Certificate of Insurance ("certificate") issued in your state of residence when you initially enrolled, and the Accident — ERISA: Claims and Appeals Information (which is available from MetLife) — constitutes the Summary Plan Description for the Wells Fargo & Company Optional Accident Insurance Plan (the "Optional Accident Insurance Plan").

The basics

General Information

This SPD is a summary of provisions for the Optional Accident Insurance Plan and its underlying fully insured policy issued by Metropolitan Life Insurance Company ("MetLife") and the corresponding Certificate of Insurance ("certificate"). For further details, after your effective date you can view your state-specific certificate by signing into metlife.com/mybenefits and following the instructions to set up your online MetLife account (enter "Wells Fargo" for "Employer"); otherwise, you can view a sample certificate by accessing metlife.com/wf (due to certain state variations, there may be differences between your state-specific certificate and the sample certificate). The SPD and Group Policy Number 164933 issued by MetLife, along with any applicable certificates, policy amendments, riders, endorsements, and the Accident — ERISA: Claims and Appeals Information (collectively the "Group Policy"). If there are differences between the SPD and the Group Policy, the Group Policy governs your rights to benefits.

Generally, within two weeks of your effective date in the Optional Accident Insurance Plan, you will be able to access the state-specific certificate for your state of residence by going to metlife.com/mybenefits and following the instructions to set up your online MetLife account (enter "Wells Fargo" for "Employer"). If you would like a free printed copy of the state-specific certificate for your state of residence, contact MetLife.

Note: The certificate is applicable to your state of residence as noted on your address in Workday when your initial enrollment in the plan is reported to MetLife. It is very important that you keep your address updated in Workday since certain eligibility provisions are based on your state of residence. This certificate generally remains in effect even if you move to another state. However, if you move to a state that does not allow eligibility for certain dependents, they will automatically lose coverage when your address is updated in Workday.

The Optional Accident Insurance Plan is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Insurer and claims administrator

The Optional Accident Insurance Plan is fully insured by Metropolitan Life Insurance Company (MetLife). MetLife is the named fiduciary for purposes of claims and appeals and has sole and complete discretionary authority to interpret the plan and to decide questions of fact as necessary to make benefit determinations. Wells Fargo is the plan administrator and has retained all other authority not delegated to MetLife herein.

Optional Accident Insurance Plan coverage

The Optional Accident Insurance Plan is not medical coverage and should not be considered a replacement for enrolling in medical coverage. The Optional Accident Insurance Plan provides a predetermined benefit payment for certain accidental injuries or specific medical treatments or services associated with a covered accident. Payments are predetermined based on the "Schedule of Insurance" section of the certificate, not based on the amount you are charged for the treatment or service. See the certificate for full benefit details on the MetLife site at metlife.com/mybenefits.

Payment is made directly to you, not your doctors or healthcare providers. You have flexibility to spend the payment on anything, including medical expenses or daily living expenses.

During your initial designated enrollment period or during Annual Benefits Enrollment, you can elect to enroll in the Optional Accident Insurance Plan for yourself and any eligible dependents you choose to cover.

You, or your eligible dependent, must be enrolled in the Optional Accident Insurance Plan on the date the accident occurs to receive applicable benefits.

After you or your eligible enrolled dependent have experienced one of the covered accidental injuries or received a covered medical treatment or service related to a covered accident, file a claim for benefits. See the Accident – ERISA: Claims and Appeals Information (which is available from MetLife) for claims filing information.

If you are enrolled in the Optional Accident Insurance Plan, you agree to authorize your provider to give MetLife information about your injury or associated treatments or services provided to determine if benefits are available under this plan. Your failure to provide this authorization or any requested information may result in denial of your claim.

Your Optional Accident Insurance Plan at a glance

Who pays the premium?	You pay the full cost of coverage
MetLife policy number	0164933
Type of ERISA plan	Welfare benefit plan
Who's eligible	Employees on U.S. payroll who have an employment classification of: • Regular or fixed term, and their eligible dependents See the "Who's eligible" section starting on page 15-5 for more information
Who's not eligible	• Employees who have an employment classification of intern or flexible • Dependents who do not meet Wells Fargo dependent eligibility criteria for this plan • You, if you are enrolled in the Optional Accident Insurance Plan as a dependent of another employee • Your dependent if that individual is already enrolled in the Optional Accident Insurance Plan as an employee or the dependent of another employee • An unborn or stillborn child
Beneficiary	If you are deceased at the time the benefit is payable, the benefit will be paid to your designated beneficiary. See the certificate for more information. To view the certificate, visit metlife.com/mybenefits.
Cost	The cost for coverage is based on the rate for the coverage level you elect: • You only • You and spouse or domestic partner • You and children • You and spouse or domestic partner and children You pay your share of the Optional Accident Insurance with after-tax deductions withheld from your pay. You authorize these payroll deductions when you enroll in the Optional Accident Insurance Plan.
Coverage effective date	**Annual Benefits Enrollment elections** Elections you make during the Annual Benefits Enrollment period are effective the following January 1 if you are still actively at work on that date; dependents are subject to the nonconfinement clause (refer to the "Delayed effective date" section on page 15-5). If you drop your coverage during Annual Benefits Enrollment, your election to drop coverage is effective on the following January 1. **New Hires and newly eligible employee elections** Generally, the first of the month after one full calendar month of service from your date of hire or employment classification change to a regular or fixed term position, provided that you enrolled during your new hire or newly eligible enrollment period and you are actively at work on the day coverage is scheduled to begin. For more information see the: • "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More" • "Delayed effective date" section on page 15-5 to understand the actively at work requirement Dependents are subject to the nonconfinement clause (refer to the "Delayed effective date" section on page 15-5). **Changes during the year** The first of the month after you access Workday to request to drop or decrease your level of coverage as permitted by the Plan.
Cancel or change coverage	Enroll or make changes during the Annual Benefits Enrollment period for any reason. You may access Workday at any other time to drop or decrease your level of coverage, but you cannot reenroll yourself or a dependent until the next Annual Benefits Enrollment period. Dependents can only be dropped mid-year if they lose eligibility. **NOTE:** If a covered dependent ceases to be eligible, coverage under the Plan ends for that dependent by virtue of ceasing to be a dependent; however, we rely on you to make the election change in Workday. Thus, it is your obligation to make the change in Workday as soon as possible to notify us that the dependent is no longer eligible. Failure to make this change in Workday may result in MetLife requesting that you repay any claims that are paid for the ineligible dependent or retroactively terminating your coverage if MetLife believes that you have engaged in fraud.

Coverage when you're not working during an approved leave of absence	If your Optional Accident Insurance coverage was already in effect on the date your approved leave of absence starts, coverage may continue when you are not actively at work during an approved leave of absence provided that you continue to pay the premiums. See the "Benefits when you're not working" section on page 15-7.

Who's eligible

General eligibility

Regular and fixed term Wells Fargo employees and their eligible dependents as described in the "Who's eligible to enroll" section of "Chapter 1: Eligibility, Enrollment, and More," are eligible for coverage under the Optional Accident Insurance Plan. Interns and flexible employees and their dependents are not eligible for coverage.

You may not be covered under the Optional Accident Insurance Plan as both an employee and a spouse or domestic partner, or as an employee and a dependent child at the same time. Also, a dependent can only be covered under one employee.

Additional eligibility rules may apply (for example, in certain states, you may be able to enroll your grandchildren) — see the certificate for details at MetLife: metlife.com/mybenefits.

Audits of dependent eligibility

Refer to the "Audits of dependent eligibility" section in "Chapter 1: Enrollment, Eligibility, and More."

Fraudulent enrollment

Refer to the "Consequences of fraudulent enrollment" section in "Chapter 1: Enrollment, Eligibility, and More."

How to enroll and when coverage begins

Refer to the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the timeframe and process for enrolling during your designated enrollment period. After you have enrolled, coverage will begin as described in the "Coverage effective date" row in the "Optional Accident Insurance Plan at a glance" table on page 15-4 subject to the "Actively at work requirement" provision for employees and the "Nonconfinement clause" for dependents (see the "Delayed effective date" section on this page for more information).

If you did not enroll when you were first eligible, see the "Changing or canceling coverage" section on this page for information about enrolling at a later date.

Delayed effective date

Actively at work requirement

If you are not actively at work on the day coverage would start for a plan year, your Optional Accident Insurance Plan coverage will begin when you return to being actively at work. "Actively at work" means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to travel or allows you to work. You will be deemed to be "Actively at work" during weekends or approved PTO, observed holidays, or temporary business closures if you were "Actively at work" on the last scheduled work day preceding such time off.

Nonconfinement clause

If you are enrolled in the Optional Accident Insurance Plan at a coverage level that covers eligible dependents, coverage will start for the dependent on the date that your coverage starts, provided that the person to be covered is not confined at home under a physician's care, receiving or applying to receive disability benefits from any source, or hospitalized* because of illness or disease ("confinement"). If so, coverage will be delayed until he or she is released from such confinement (known as the "nonconfinement clause" and referred to as "medical restriction" in the certificate).

*Hospitalized for the purposes of the nonconfinement clause means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long-term care facility; or receipt of chemotherapy, radiation therapy, or dialysis regardless of where the care is administered.

Changing or canceling coverage

If you did not enroll in Optional Accident Insurance during Annual Benefits Enrollment or your initial designated enrollment period, you must wait until the next Annual Benefits Enrollment period to enroll. If you enrolled in Optional Accident Insurance but did not enroll your eligible dependents, you must wait until the next Annual Benefits Enrollment period to enroll your eligible dependents (with the exception for a newly eligible child, as described below). To add eligible dependents, you must already be enrolled or elect to enroll in Optional Accident Insurance (provided that you are eligible).

A newly eligible child, as defined in "Chapter 1: Eligibility, Enrollment, and More", who becomes eligible while your insurance is in effect (for example, a newborn or newly-adopted child) may be automatically covered, without enrollment, through the last day of the plan year that follows the next open enrollment period (the newly eligible child will not display as covered on your Benefits Statement during this period). To continue coverage

for the child, you must enroll the child at the next available opportunity during open enrollment at which point they will display on your Benefits Statement. See the certificate for more information and requirements. To view the certificate, visit metlife.com/mybenefits.

You must promptly access Workday to drop an enrolled dependent who is no longer eligible. You may otherwise drop your coverage at any time, but you may only reenroll or add an eligible dependent during the next Annual Benefits Enrollment period.

For the coverage effective date after making a change to your coverage election, see the "Coverage effective date" row in the "Optional Accident Insurance Plan at a glance" table on page 15-4.

Cost

You must pay the full cost for coverage, including any coverage for eligible enrolled dependents. Each pay period, you pay premiums for your Optional Accident Insurance Plan coverage through after-tax payroll deductions. Wells Fargo does not contribute toward payment of the premium. You authorize these after-tax payroll deductions by enrolling in the Optional Accident Insurance.

The amount you pay for coverage depends on the coverage level you elect.

- You only
- You and spouse or domestic partner
- You and children
- You and spouse or domestic partner and children

Beneficiaries

A beneficiary may be named by you to receive a benefit that becomes payable to you under this benefit that you are not alive to receive. Please refer to the certificate for beneficiary information and information on what happens if you do not designate a beneficiary. To view the certificate, visit metlife.com/mybenefits.

Adding or changing beneficiaries

You may add or change beneficiaries under the Optional Accident Insurance Plan at any time by accessing the MetLife site, at metlife.com/mybenefits, or you can call MetLife, at 1-866-549-2320 to request a beneficiary designation form. The change becomes effective on the date you updated your beneficiary on the MetLife site or the date your completed form is received by Metlife.

Optional Accident Insurance Plan benefits

Optional Accident Insurance Plan coverage is designed to pay a benefit if you or your covered family member is enrolled in the Optional Accident Insurance Plan and experience a covered accidental injury or covered medical services related to a covered accident that occurs while coverage is in effect.

Review the certificate for the schedule of covered benefits and conditions and information on what is not covered. To view the certificate, visit metlife.com/mybenefits.

Payment of the accidental injury benefits under the plan are subject to all of the conditions, maximums, limitations, exclusions, proof requirements, definitions, and terminology stated in the Insurance Documents (defined at the beginning of this SPD), including the certificate applicable to your state of residence.

Optional Accident Insurance Plan claims and appeals

You have certain rights and obligations with respect to claims for benefits. The details surrounding those rights and obligations, including but not limited to the time period for filing claims, where to file claims, the time period for appealing any Adverse Benefit Determinations – are generally set forth in the "Accident – ERISA: Claims and Appeals Information" (which is available from MetLife). However, we have identified the fundamental rights and obligations of both the Plan and you with respect to claims and appeals, as prescribed by ERISA.

For purposes of this SPD, an "Adverse Benefit Determination" means a denial, in whole or part, of any request for benefits from a benefit plan.

- You have the right to have an authorized representative file a claim for benefits on your behalf. Whether a representative is authorized to act on your behalf will be determined in accordance with the "Accident – ERISA: Claims and Appeals Information" (which is available from MetLife) or MetLife's reasonable procedures.
  - The Plan may establish reasonable procedures for filing claims for benefits. The specific claim filing procedures will be described in the "Accident – ERISA: Claims and Appeals Information" (which is available from MetLife).
- If you receive an Adverse Benefit Determination, you will receive a notice of the Adverse Benefit Determination that contains the following information:
  - Reference to the specific plan provisions on which the denial is based
  - A description of information necessary to perfect your claim
  - A description of the Plan's procedures for filing an appeal of the Adverse Benefit Determination
  - A statement of your right to file suit under ERISA 502 (provided you exhaust the Plan's claims and appeal procedures)

- You have the right to receive from MetLife upon request and free of charge, reasonable access to and copies of all documents and records that are "relevant" to your claim for benefits (as defined by ERISA).
- You generally may not file suit until you have exhausted the Plan's internal claims and appeals process.

Named claims fiduciary

MetLife (the insurer) shall serve as the named fiduciary under the Optional Accident Insurance Plan and shall have sole and complete discretionary authority to determine conclusively for all parties and, in accordance with the terms of the documents or instruments governing the Optional Accident Insurance Plan, any and all questions arising from:

- Administration of the Optional Accident Insurance Plan claims and interpretation of all provisions of the Optional Accident Insurance Plan
- Determination of all facts that are relevant to a claim for benefits
- Determination of the documents, records, and other information that is relevant to a claim for benefits
- Determination of the benefits to be provided to any participant or beneficiary
- Construction of all terms of the Optional Accident Insurance policy

Decisions by MetLife shall be conclusive and binding on all parties.

Neither the plan administrator nor Wells Fargo provides any review of claims made or pays any benefits to Optional Accident Insurance Plan participants.

Legal action

There is a period of time after which you will not be entitled to take legal action. See the certificate for more information regarding that limitation. To view the certificate, visit metlife.com/mybenefits.

Right of recovery

If, at any time, MetLife determines that benefits paid under this plan were more than the benefits due:

- You, or any other person or entity to whom MetLife overpaid benefits, have the obligation to reimburse MetLife for the amount of such overpayment
- MetLife has the right to recover the amount of such overpayment from you, or any other person or entity to whom MetLife overpaid benefits, including offsetting future benefits payable under this plan to you or such other person or entity by an amount equal to the overpayment

This provision will not be interpreted to create a right of subrogation by MetLife.

Benefits when you're not working

You must continue paying the premiums to maintain Optional Accident Insurance Plan coverage while you are on an approved leave of absence. For more information about paying premiums while on a leave of absence, see "Appendix D: Leaves of Absence and Your Benefits". If coverage is canceled due to nonpayment of premiums while you are on an approved leave of absence, you must wait until the next Annual Benefits Enrollment period to reenroll. Coverage is effective January 1 of the year following your Annual Benefits Enrollment election, provided you are actively at work on the day coverage is scheduled to begin.

When coverage ends

Coverage under the Optional Accident Insurance Plan ends on the last day of the month in which one of the following events occurs:

- Your last day of employment or the last day of your severance eligibility period under the Wells Fargo & Company Severance Plan, whichever is later[1]
- You no longer meet the eligibility requirements
- You voluntarily make a permitted election change to drop coverage (Exception: If you make an election to drop coverage during Annual Benefits Enrollment, that coverage ends December 31 of the year in which the Annual Benefits Enrollment election was made)

Coverage under the Optional Accident Insurance Plan will also end if you stop paying the required premiums or if the Optional Accident Insurance Plan is discontinued or terminated regardless of any of the events noted above.[2]

1. If you are rehired by Wells Fargo as a regular or fixed term employee and your first day of reemployment occurs during your severance eligibility period, any benefits that are in effect on the day before your rehire will continue as a rehired employee. For more information, see the "Rehired employees" section in "Chapter 1: Enrollment, Eligibility, and More".
2. For information on Wells Fargo's ability to amend, modify, or terminate the Optional Accident Insurance Plan, see the "Future of the plans" section in "Appendix B: Important Notifications and Disclosures."

If you die, coverage ends on your date of death.

Coverage for your covered dependents ends when they no longer meet the eligibility requirements. Coverage for all of your covered dependents also ends when your coverage ends or upon your death.

In certain states, state insurance law may require MetLife to provide continuation of coverage when coverage ends, as set forth in the certificate.

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Appendix A: Claims and Appeals

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Claims determinations and dispute resolution with respect to out-of-network emergency care and eligible non-emergency services **A-19**

A claimant is entitled to a full and fair review of any claims made under a group health plan, including the medical, dental, and vision plan benefit options under the Wells Fargo & Company Health Plan (the Health Plan) and the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA under the Wells Fargo & Company Health Care Flexible Spending Account Plan (the Health Care FSA Plan).

This appendix describes the claims and appeals procedures for the following:

Wells Fargo & Company Health Plan

- UnitedHealthcare administered:
  - Copay Plan with HRA[1,2]
  - Higher Use Plan with HSA[1,3]
  - Lower Use Plan with HSA[1,3]
  - Narrow Network Plan with HSA[3]
  - Narrow Network Copay Plan
  - Flex HDHP[1]
- Anthem Blue Cross Blue Shield administered:
  - Copay Plan with HRA[1,2]
  - Higher Use Plan with HSA[1,3]
  - Lower Use Plan with HSA[1,3]
  - Narrow Network Plan with HSA[3]
  - Narrow Network Copay Plan
  - Flex HDHP[1]
- Aetna administered:
  - Copay Plan with HRA[1,2]
  - Higher Use Plan with HSA[1,3]
  - Lower Use Plan with HSA[1,3]
  - Narrow Network Plan with HSA[3]
  - Narrow Network Copay Plan
  - Flex HDHP[1]
- Express Scripts administered prescription drug benefit:
  - Copay Plan with HRA[1,2]
  - Higher Use Plan with HSA[1,3]
  - Lower Use Plan with HSA[1,3]
  - Narrow Network Plan with HSA[3]
  - Narrow Network Copay Plan
  - Flex HDHP[1]
- Delta Dental Standard and Enhanced
- Vision Service Plan (VSP)

1. Including Out of Area coverage.
2. HRA claims are administered by HealthEquity.
3. Your HSA is not part of the Health Plan and these claims and appeals procedures do not apply. Refer to "Appendix C: Health Savings Accounts" for more information about your HSA.

Wells Fargo & Company Health Care Flexible Spending Account Plan

- Full-Purpose Health Care FSA
- Limited Dental/Vision FSA

Additional claims procedures specific to each particular benefit option previously listed are also found in the individual medical, dental, vision, and flexible spending accounts chapters of this *Benefits Book*.

Important information about health and wellness activities and dollars:

- If you are enrolled in the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, or an HDHP Kaiser medical plan option and have completed a health and wellness activity but have not had the applicable earned health and wellness dollars deposited into your health reimbursement account or health savings account, as applicable, within 30 days of the date you completed the activity, see the "Health and wellness dollar disputes" section in "Chapter 2: Medical Plans" for information about filing a formal inquiry (open a case for investigation) with Optum and Rally Health. Because Optum and Rally Health are the administrators of all health and wellness activities that allow you or your covered spouse or domestic partner to earn health and wellness dollars, you must submit an inquiry to Optum and Rally Health; you cannot appeal the availability of health and wellness dollars with your claims administrator. Your inquiry to Optum and Rally Health will function as your appeal with respect to these health and wellness dollars.
- While the health and wellness activities under the Copay Plan with HRA, Higher Use Plan with HSA, Lower Use Plan with HSA, Narrow Network Plan with HSA, or the HDHP Kaiser medical plan options are not outcome-based (that is, they do not require you to achieve particular health outcomes), there may be situations where you are unable to complete a biometric screening, or other qualified activity, to earn health and wellness dollars. Please see the "Requests for accommodations" section in "Chapter 2: Medical Plans" for more information on how to request an accommodation with Optum and Rally Health; you cannot request the accommodation through your claims administrator.

If you are enrolled in a fully insured Kaiser medical plan option under the Health Plan, refer to the Evidence of Coverage or similar documentation provided directly from or made available to you by Kaiser (visit https://my.kp.org/wf or kp.org/eoc) for applicable claims appeals and procedures.

If you are enrolled in the fully insured UnitedHealthcare Global — Expatriate Insurance plan, refer to the separate Certificate of Coverage, Summary Plan Description, or similar documentation that you received upon enrolling in the plan for applicable claims appeals and procedures.

For information about the claims and appeals procedures for benefit options not addressed above, refer to the applicable chapter within this *Benefits Book*.

The claims and appeals procedures stated in this appendix are intended to comply with applicable regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions, and appeals of adverse benefit determinations. You'll need to follow these procedures for all claims for benefits arising from each benefit option listed above.

Your claim will be processed for payment according to the applicable plan provisions, the guidelines used by the applicable claims administrator, and the claim coding submitted by the provider. The applicable claims administrator is the named claims and appeals fiduciary and has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the Summary Plan Description (SPD) or other instruments governing the applicable plan or benefit option.

An issue or dispute solely regarding your eligibility for coverage or participation in one or more of the plans or benefit options is not considered a claim for benefits and is not governed by the claims and appeals procedures described in this appendix. For more information, please call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

Claims

A claim is any request for a plan benefit made in accordance with these claims procedures.

A claim is considered to be filed when it is received by the applicable claims administrator in accordance with these claims procedures. The time period for providing notice of a determination starts when the claim is filed, regardless of whether the claims administrator has all of the information necessary to decide the claim at the time the claim is filed.

If a claim does not include sufficient information for the claims administrator to make an initial benefit determination, you may be asked to provide additional information needed to make the determination. Your failure to provide the additional information requested within the applicable time period identified in the "Initial claims procedures" table on page A-10 may result in the denial of your claim, in whole or in part.

For purposes of this appendix, references to "you" may include your authorized representative or your provider if your provider is submitting a claim on your behalf. To authorize someone to represent you through the claims process, you must submit a written authorization to the applicable claims administrator. The authorization must specify who is representing you, for what purpose, for what duration of time, and what documents, records, or other items may be released to or requested of this representative. For more information, see the "Authorizing a representative" section on page A-12. In the case of a claim involving urgent care, a health care professional with knowledge of your medical condition shall be permitted to act as your authorized representative.

There are four types of claims, defined under the "Definitions" section starting on this page. Different claims and appeals procedures, as described in this appendix, apply to each type of claim.

Definitions

Adverse benefit determination

An adverse benefit determination means any of the following:

- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of your eligibility to participate in a benefit option under the Health Plan or the Health Care Flexible Spending Account Plan
- Failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, unproven, or investigational, or not medically necessary or appropriate

Note: A rescission of coverage as defined under the Affordable Care Act is an adverse benefit determination, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time. Refer to the "Appealing an adverse benefit determination — rescission of coverage" section on page A-19 for more information.

Authorized Representative

An individual with respect to whom a covered individual has authorized, in accordance with the Claims Administrator's policies and procedures, to file claims and appeals on behalf of the individual. An assignment of benefits to a provider or facility is not considered to be a proper authorization unless it satisfies the Claims Administrator's policies and procedures.

Claimant

A claimant is an individual covered under the plan, or their authorized representative, making a claim for benefits under that benefit option.

Concurrent care claim

A claim is a concurrent care claim if the applicable claims administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments and one of the following is true:

- The claims administrator determines that the approved course of treatment should be reduced or terminated before the end of such period of time or number of treatments have been completed.

  Note: This does not apply where the reduction or termination is due to plan amendment or plan termination.

- You request extension of the course of treatment or number of treatments beyond what the claims administrator has approved (when pre-service approval is required and the continuing services have not yet been provided).

Post-service claim

Post-service claims are all claims that are not pre-service claims, such as a claim for benefits after you receive health care services.

Pre-service claim

A pre-service claim is any claim for a plan benefit where the payment of the benefit is conditioned in whole or part on receiving the advance approval or authorization from the applicable claims administrator before obtaining services. Depending on the claims administrator, a pre-service claim may also be referred to as prior authorization.

If a service requires pre-service authorization to receive benefits but the service is provided before receiving authorization or approval from the applicable claims administrator, the claim will be reviewed as a post-service claim.

Note: Casual inquiries about the benefits or the circumstances under which benefits might be paid under your benefit option are not considered pre-service claims subject to these procedures, nor are requests for approval when preapproval is not required to receive benefits.

Urgent care claim

An urgent care claim is any pre-service claim for medical care or treatment with respect to which the application of the time periods for making pre-service care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a pre-service claim is an urgent care claim will be determined by the attending provider, and the claims administrator and the Health Plan will defer to such determination of the attending provider who filed the urgent care claim. Where the attending provider has not determined that the claim is an urgent care claim, whether the claim is an urgent care claim will be determined by an individual acting on behalf of the Health Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Important: If you need medical care for a condition that could seriously jeopardize your life, you should obtain such care without delay. Benefits will be determined when the claim is processed.

Services from a network (or in-network) provider

Generally, your network (also known as in-network) provider will determine whether your claim is an urgent care, pre-service, or post-service claim and will submit pre-service authorization requests and claims for final payment directly to the applicable claims administrator for you. After services have been rendered and a post-service claim has been filed and processed, benefits payments for covered services are made directly to the network provider. You are responsible for meeting any annual deductible and for paying the applicable copay or coinsurance to a network provider. You are also responsible for payment in full for any charges incurred that are not covered by the plan. Therefore, you should discuss your care with your network provider and make sure your network provider obtains any necessary pre-service authorizations before services are rendered.

However, you are not responsible for any charges a network provider is required to write off as a result of the network provider's contract with the claims administrator or the claims administrator's associated networks. The claims and appeals procedures described in this appendix do not apply to requests by health care providers for payments due to them in accordance with contractual arrangements between the provider and the Health Plan's claims administrator for the applicable benefit option where the provider has no recourse against you for amounts, in whole or in part, not paid by the Health Plan as directed by the claims administrator.

Services from an out-of-network provider

If you are using an out-of-network (also known as "non-network") provider, it is your responsibility to make sure that the claim is filed correctly and on time even if the out-of-network provider offers to assist you with the filing. This means that you may need to determine whether your claim is a pre-service, urgent care, concurrent care, or post-service claim. After you determine the type of claim, you must follow the specific procedures for that type of claim.

If you file a post-service claim after services have been rendered, when the claim is processed, benefits payments for covered services will be issued to you. You are responsible for paying the out-of-network provider in full.

If you provide written authorization to allow direct payment to the out-of-network provider, benefits may be paid directly to the out-of-network provider instead of being paid to you if either of the following is true:

- The out-of-network provider notifies the applicable claims administrator that your signature is on file, assigning benefits directly to that provider.
- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

An authorization or assignment to pay a provider generally does not assign any other rights under the applicable plan to that provider, including the right to request plan documents or pursue and appeal an adverse benefit determination on your behalf.

Note: If the provider assigns their benefits to another party, the plan will still pay only your provider. However, any benefits under the Delta Dental coverage options for services received from an out-of-network provider will be paid directly to you, regardless of any assignment of benefits on file.

You are responsible for meeting any annual deductible and for paying established copayments (if applicable) and coinsurance to the out-of-network provider. You are also responsible for payment in full of any charges incurred that are not covered by the plan, including amounts the out-of-network provider has billed in excess of the allowed amount.

Notwithstanding anything to the contrary herein, the claims administrator will communicate its determinations directly and will make payment of benefits (if any) to the out-of-network provider (including an out-of-network facility) of the following

services to the extent that the claim is properly filed by the provider and the provider has submitted documentation required by the claims administrator verifying it as the provider of such services:

- "Emergency care" services (including any additional services), as defined in "Chapter 2: Medical Plans" in this *Benefits Book*.
- Eligible non-emergency services, as defined in "Chapter 2: Medical Plans" in this *Benefits Book*.

Filing a pre-service, urgent care, or concurrent care claim

In general, if you receive services from a network provider, the network provider will file a pre-service, urgent care, or concurrent care claim on your behalf. However, you should always check with your network provider to make sure that the claim has been filed and that the services have been authorized by the claims administrator, if required by the Health Plan benefit option, before you receive the services.

When you receive services from an out-of-network provider, you're responsible for ensuring that the pre-service, urgent care, or concurrent care claim is filed correctly and that the services have been authorized by the claims administrator before you receive services, even if the out-of-network provider offers to file the claim on your behalf.

The following information is required for filing a pre-service, urgent care, or concurrent care claim:

- Patient's name, date of birth, and relationship to the participant or employee
- Wells Fargo group number and individual member number
- Medical condition (diagnosis) and the treatment or service for which approval is being requested
- Service provider's name
- Medical records or other documentation to support the request for approval
- Any additional information requested by the claims administrator upon notification

Note: If the services are provided before a determination is made for a claim that started out as a pre-service, urgent care, or concurrent care claim, the claim may be treated as a post-service claim.

Failure to follow claims procedures — pre-service, urgent care, and concurrent care claims

If you do not follow proper claims procedures, the claims administrator will notify you of the failure and the proper procedures to be followed. Such notification may be verbal unless you specifically request written notification.

- For **pre-service** claims, you will be notified within five days from the date the claims administrator received the request.
- For **urgent care** claims, you will be notified as soon as possible but not later than within 24 hours from the time the claims administrator received the request. Notification may be verbal unless you specifically request written notification.
- For **concurrent care** claims, you will be notified as noted above depending on whether the request qualifies as an urgent care claim or a pre-service claim.

Contacts for pre-service, urgent care, and concurrent care claims

Benefit option	Contact
UnitedHealthcare administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	UnitedHealthcare 1-800-842-9722 For urgent care claims, specifically state that the claim is an urgent care claim. UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130 For prescription drug claims, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.
Anthem Blue Cross Blue Shield administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	Anthem Blue Cross Blue Shield 1-866-418-7749 For urgent care claims, specifically state that the claim is an urgent care claim. Anthem Blue Cross Blue Shield 17 Plaza Drive Mail Drop NY59-17-3L-999 Latham, NY 12110 For prescription drug claims, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.
Aetna administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	Aetna 1-877-320-4577 For urgent care claims, specifically state that the claim is an urgent care claim. Aetna PO Box 981106 El Paso, TX 79998 For prescription drug claims, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.
Express Scripts administered prescription drug benefit: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	• For urgent care claims, your physician must submit the urgent care claim request by calling Express Scripts at 1-800-753-2851. • For nonurgent, pre-service, and concurrent care claims, your physician must submit the request electronically to Express Scripts. Information about electronic options can be found at express-scripts.com/PA. • For questions about the authorization process, call 1-855-388-0352.
Fully insured medical plans (including the insured Kaiser medical plan options and UnitedHealthcare Global — Expatriate Insurance)	For information, refer to your Evidence of Coverage, Certificate of Coverage, Summary Plan Description, or similar documentation provided directly from or made available to you by the insurer.
Delta Dental: • **Standard** • **Enhanced**	Not applicable. For pretreatment estimates, see "Chapter 3: Dental Plan."
Vision Service Plan (VSP)	Not applicable.
• **Health Reimbursement Account (HRA) claims under the Copay Plan with HRA** • **Flexible spending accounts:** – **Full-Purpose Health Care FSA** – **Limited Dental/Vision FSA** **Note:** Claims for benefits under the Day Care FSA are not governed by the claims and appeals procedures set forth in this appendix because the Day Care FSA is not governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA) and does not provide for medical care. For more information, refer to "Chapter 6: Day Care Flexible Spending Account."	Not applicable.

Filing a post-service claim

Post-service claims must contain all the information described in this section (except for Full-Purpose Health Care FSA or Limited Dental/Vision FSA claims, which are addressed in "Chapter 5: Health Care Flexible Spending Account Plan (Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)". If you don't submit the necessary information to the applicable claims administrator within the time frame for claims submissions for the applicable benefit option, benefits for the services received will be denied. Refer to the "Contacts for post-service claims" table starting on page A-8 for important information about claim submission deadlines and the address to which claims should be submitted.

- In general, if you receive services from a network provider, the network provider will file a post-service claim on your behalf. However, you should always check with your network provider to make sure the claim has been filed within the proper time frame to avoid denial of benefits for missing the claim filing deadline.
- If you receive services from an out-of-network provider, you're responsible for ensuring that the claim is filed correctly and on time, even if the out-of-network provider offers to file the claim on your behalf. You must complete the appropriate claim form and provide an itemized original bill* from your out-of-network provider that includes all of the following:
  - Patient's name, date of birth, and patient diagnosis codes
  - Dates of service
  - Procedure codes and descriptions of services rendered
  - Charge for each service rendered
  - Provider's name, address, and tax identification number
  - For prescription drugs, a prescription drug receipt and documentation that includes the patient's name, date of service, prescription number, name of medication, strength and quantity of medication, prescribing physician's name, pharmacy name and address, and the cost of medication

* Monthly statements or balance due bills and credit card receipts are not acceptable. Photocopies are only acceptable if you're covered by two plans and you sent the original bill to the primary payer.

You can get a claim form directly from the applicable claims administrator (see the "Contacts" section at the beginning of the applicable chapter in this *Benefits Book*, or refer to your member ID card, for the phone number of your claims administrator).

Claims for separate family members should be submitted separately. If you have other coverage that is primary and pays benefits before your benefit option under the Health Plan (for example, another employer's plan or Medicare), you must submit your claim to such primary coverage before submitting a claim under the Health Plan. After the primary coverage has processed the claim and has paid any benefits, you can then file your claim with the applicable claims administrator for the Health Plan. You must still file your claim under the Health Plan within the applicable time frame for filing claims. When you file your claim under the Health Plan, you must attach your Explanation of Benefits statement from your primary coverage.

It is important to keep copies of all submissions because the documentation you submit won't be returned to you.

Your claim will be processed for payment according to the applicable plan provisions, the guidelines used by the applicable claims administrator, and the claim coding submitted by the provider.

Filing a post-service HRA claim

If you are enrolled in the Copay Plan with HRA and pay a claim out of pocket instead of using your HealthEquity Healthcare Card, you will need to file a Pay Me Back claim with HealthEquity to use available HRA dollars to reimburse yourself. You can also choose to Pay My Provider directly from your account to pay for eligible expenses. Neither your network provider nor your out-of-network provider can file the claim for you. See the "Non-HealthEquity Healthcare Card HRA transactions" section in "Chapter 2: Medical plans" for more information on submitting a claim for HRA dollars.

Contacts for post-service claims

Benefit option	Contact	Time frame for claim submission
UnitedHealthcare administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130	**In-network services:** For services received from in-network providers, the in-network providers are required to file the claim within the time period specified in their contract with the claims administrator, but in no case will a claim be eligible for benefits if filed more than 12 months from the date of service. **Out-of-network services:** For services received from out-of-network providers, you or the provider are required to file the claim within 12 months from the date of service.
	For prescription drug claims, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.	
Anthem Blue Cross Blue Shield administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	Anthem Blue Cross Blue Shield PO Box 60009 Los Angeles, CA 90060 1-866-418-7749	**In-network services:** For services received from in-network providers, the in-network providers are required to file the claim within the time period specified in their contract with the claims administrator, but in no case will a claim be eligible for benefits if filed more than 12 months from the date of service. **Out-of-network services:** For services received from out-of-network providers, you or the provider are required to file the claim within 12 months from the date of service.
	For prescription drug claims, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.	
Aetna administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	Aetna Claims PO Box 981106 El Paso, TX 79998	**In-network services:** For services received from in-network providers, the in-network providers are required to file the claim within the time period specified in their contract with the claims administrator, but in no case will a claim be eligible for benefits if filed more than 12 months from the date of service. **Out-of-network services:** For services received from out-of-network providers, you or the provider are required to file the claim within 12 months from the date of service.
	For prescription drug claims, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.	
Express Scripts administered prescription drug benefit: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	Express Scripts Attn: Benefit Coverage Review Department PO Box 66587 St. Louis, MO 63166-6587 Fax: 1-877-328-9660	Claims must be received no later than 12 months from the date the prescription drug or covered supplies were dispensed.

Benefit option	Contact	Time frame for claim submission
Fully insured medical plans (including the insured Kaiser medical plan options and UnitedHealthcare Global — Expatriate Insurance)	For information, refer to your Evidence of Coverage, Certificate of Coverage, Summary Plan Description, or similar documentation provided directly from or made available to you by the insurer.	
Delta Dental: • **Standard** • **Enhanced**	Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120	**In-network services:** For services received from in-network providers, the in-network providers are required to file the claim within 12 months from the date of service. **Out-of-network services:** For services received from out-of-network providers, you are responsible for filing the claim within 12 months from the date of service.
Vision Service Plan (VSP)	VSP PO Box 385018 Birmingham, AL 35238	**In-network services:** For services received from in-network providers, the in-network providers are required to file the claim within six months from the date of service. **Out-of-network services:** For services received from out-of-network providers, you are responsible for filing the claim within 12 months from the date of service.
• **Health Reimbursement Account (HRA) claims under the Copay Plan with HRA** • **Flexible Spending Accounts:** – **Full-Purpose Health Care FSA** – **Limited Dental/Vision FSA** **Note:** Claims for benefits under the Day Care FSA are not governed by the claims and appeals procedures set forth in this appendix because the Day Care FSA is not governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA) and does not provide for medical care. For more information, refer to "Chapter 6: Day Care Flexible Spending Account."	Claims Administrator — HealthEquity PO Box 14053 Lexington, KY 40512 • Fax: 1-877-353-9236 • Scan and upload through https://participant.wageworks.com • Use the HealthEquity mobile app on your personal device (not a Wells-Fargo issued device)	• HRA claims under the Copay Plan with HRA must be filed within 12 months from the date of service. Refer to the "Non-HealthEquity Healthcare Card HRA transactions" section in "Chapter 2: Medical Plans" for more information. • FSA claims for eligible expenses incurred during the plan year and the grace period must be filed by the following April 30. Refer to "Chapter 5: Health Care Flexible Spending Account Plan (Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)" for more information.

Claim determinations, determination extensions, and requests for additional information

If you have properly followed the claims procedure, the claims administrator will issue a written determination within a reasonable period of time but not later than the time frame listed in the table below.

If a claim cannot be processed because you didn't provide sufficient information, the claims administrator will notify you of the additional information needed and the time frame you have to submit the additional information to it as noted in the table below. If you don't provide the necessary information within the required time frame, your claim may be denied, in whole or in part.

If the claims administrator determines that it needs an extension of time due to matters beyond its control, the claims administrator will notify you of the reasons for the extension and the date it expects to render a decision.

Claims determinations by the claims administrator for out-of-network emergency care services (as defined in "Chapter 2: Medical Plans" in this *Benefits Book*) and eligible non-emergency services (as defined in "Chapter 2: Medical Plans" in this *Benefits Book*) will be governed solely by the section at the end of this "Appendix A: Claims and Appeals" titled "Claims determinations and dispute resolution with respect to out-of-network emergency care and eligible non-emergency services."

Initial claims procedures

Claim type	You will be notified of a determination:	Extension of time for the claims administrator to make a determination	If the claims administrator needs additional information:
Pre-service	Within a reasonable period of time, but not later than 15 days after receipt of the claim.	One extension period up to 15 days.	You will have at least 45 days from receipt of the notice to provide the requested information.
Pre-service involving urgent care	As soon as possible, but not later than 72 hours after receipt of the claim if no additional information is necessary. If additional information is necessary, you will be notified of a determination as soon as possible, but not later than 48 hours after the earlier of (1) receipt of requested information, or (2) the expiration of the time period given to provide the requested information.	None permitted.	You will be notified as soon as possible, but not later than 24 hours after receipt of the claim. You will then have at least 48 hours to provide the requested information.
Concurrent care: To end treatment prematurely or reduce treatment	At a time before treatment ends or is reduced that is sufficient to allow you to appeal the decision and receive a decision on appeal before the treatment ends or is reduced.	None permitted.	Not applicable.
Concurrent care: To request extension of treatment	Within a reasonable period of time, but not later than 15 days after receipt of the claim.	One extension period up to 15 days.	You will have at least 45 days from receipt of the notice to provide the requested information.
Concurrent care involving urgent care	As soon as possible, but within 72 hours after receipt of the claim, provided that such claim is received at least 72 hours before the expiration of the prescribed number of treatments or period of time.	None permitted.	You will be notified as soon as possible but not later than 24 hours after receipt of the claim. You will then have at least 48 hours to provide the requested information.
Post-service	Within a reasonable period of time, but not later than 30 days after receipt of the claim.	One extension period up to 15 days.	You will have at least 45 days to provide the information.

Content of the claim determination notice

Regardless of the type of claim, you will receive a notice of any adverse benefit determination in written or electronic form. The notice will provide the following information:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the determination is based.
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.
- A description of the plan's claim review procedures and a statement regarding your right to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended (ERISA) Section 502(a) following an adverse benefit determination on appeal.
- If applicable, a statement indicating the internal rule, guideline, or protocol that was relied upon to make the adverse determination and that a copy of such rule will be provided free of charge to you upon request.
- If the adverse determination is based on medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request.
- If the claim is for urgent care, a description of the expedited review process.
- For medical claims, the determination will also include information sufficient to identify the claim involved.
- Any additional information required under applicable law.

Questions about claim determinations

If you have a question or concern about a claim, you may call the claims administrator's member services department. See the "Contacts" section at the beginning of the applicable chapter in this *Benefits Book*, or refer to your member ID card for the phone number of your claims administrator. You also have the right to file a request for an internal appeal review without first calling the claims administrator's member services department.

An internal appeal must be filed with the applicable claims administrator within 180 calendar days from the date you receive the adverse benefit determination notification regardless of any discussions or consultations that have occurred regarding your claim.

Appealing an adverse benefit determination — claims

If you disagree with an adverse benefit determination on a claim, you have the right to have your adverse benefit determination reviewed on appeal. The plans and benefit options listed on page A-2 have an internal appeal review process. The medical plan benefit options also have an external review process that is applicable to certain adverse benefit determinations. Generally, you must exhaust the internal appeal process before seeking any available external review or bringing a civil action under Section 502(a) of ERISA.

A request for an internal appeal review must be filed with the applicable claims administrator within 180 days of the date you receive the adverse benefit determination notification regardless of any discussions or consultations that have occurred regarding your claim.

For purposes of this appendix, references to "you" may include your provider (if your provider is authorized to appeal on your behalf) or another authorized representative.

The appeal process does not, however, apply to any charges a network provider is required to write off as a result of the network provider's contract with the claims administrator or the claims administrator's associated networks. The claims and appeals procedures described in this appendix do not apply to requests by health care providers for payments due to them in accordance with contractual arrangements between the provider and the Health Plan's claims administrator for the applicable benefit option where the provider has no recourse against you for amounts, in whole or in part, not paid by the Health Plan as directed by the claims administrator. If there is no patient liability for the claim, there is no appeal option under the Health Plan.

If an out-of-network provider (including an out-of-network facility) disagrees with the claims administrator's determination regarding any out-of-network emergency care services (as defined in "Chapter 2: Medical Plans" in this *Benefits Book*) and eligible non-emergency services (as defined in "Chapter 2: Medical Plans" in this *Benefits Book*) provided, the provider and the claims administrator will follow the dispute resolution process described in the "Claims determinations and dispute resolution with respect to out-of-network emergency care and eligible non-emergency services" section at the end of this Appendix.

Definitions

Authorized representative

An authorized representative is an individual you have authorized in accordance with the Plan's requirements to file claims and appeals on your behalf.

External review process

The external review process is an appeal option available for appeals involving medical judgment after the internal claims and appeals review process has been exhausted and the adverse benefit determination has been upheld. The external review is conducted by an independent review organization (IRO).

Internal appeal process

The internal appeal process is the appeal review of an adverse benefit determination conducted by the claims administrator.

Medical judgment

Medical judgment includes decisions that are based on the applicable medical plan's or claims administrator's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; determination that a treatment is experimental or investigational; or as otherwise defined by applicable law. In connection with the external review process, whether an adverse benefit determination involves medical judgment is generally determined by the external reviewer.

Authorizing a representative

You have the right to have someone file an appeal on your behalf or represent you in the appeal process.

To authorize someone (including your physician) to represent you through the internal appeal process, most claims administrators require that you submit a written authorization to them on their approved form.* You can call the claims administrator to request an authorization form. However, if the claims administrator does not require you to complete a specific form, simply submit a written authorization statement with your appeal. Your authorization statement must specify:

- The name and address of the person authorized to represent you
- The purpose for which they are representing you (for example, appeal)
- The time period for which the individual will be your authorized representative
- The types of documents, records, or other items that may be requested of or released to the authorized person

*A physician with knowledge of the patient's condition may automatically be considered an authorized representative for the purpose of an urgent care claim appeal without your specific authorization.

Note: Neither the plan administrator, Wells Fargo, nor any of the Wells Fargo-sponsored plans are responsible for your authorized representative's disclosure of information provided to the authorized representative or their failure to protect such information.

If you wish for an authorized representative to request and receive a copy of the SPD or a plan document on your behalf, an authorization for representation statement as described above must be submitted to the plan administrator with the SPD or plan document request described on page A-13.

Filing an internal appeal

You must file an internal appeal with the applicable claims administrator within 180 days of the date you receive the adverse benefit determination notification, regardless of any discussions or consultations regarding the claim. Your failure to comply with this important deadline may cause you to forfeit any right to any further review under these claims and appeals procedures or in a court of law.

Urgent claim appeals may be filed verbally. All other claim appeals must be filed in writing. **Note:** For Aetna, Anthem, and UnitedHealthcare, many other claim appeals may also be filed verbally, however, requests for external reviews and appeals filed on your behalf must be filed in writing. If your claims administrator does not accept a verbal appeal for a non-urgent claim, you must file a written appeal. For questions, contact your claims administrator.

An appeal is filed when the applicable claims administrator receives a request for appeal from you (or your authorized representative) in accordance with these appeal procedures. An appeal filed by mail will not be timely received if it is postmarked later than 180 days from the date you receive the adverse benefit determination notification. For the address to which an urgent care claim or concurrent care claim appeal should be submitted, refer to the "Contacts for urgent care claim and concurrent care claim appeals" table on page A-14. For the address to which a pre- or post-service claim appeal should be submitted, refer to the "Contacts for pre- and post-service claim appeals" table on page A-15.

The time period for providing notice of an appeal determination varies by the type of claim as described below.

Type of claim appeal	You will be notified of a determination:
Urgent care	As soon as possible, but not later than 72 hours from receipt of the appeal
Pre-service	Within a reasonable period of time, but not later than 30 days from receipt of the appeal
Concurrent care	In the appeal time frame for pre-service, urgent care, or post-service claims as appropriate to the request
Post-service	Within a reasonable period of time, but not later than 60 days from receipt of the appeal

The applicable time periods begin to run when the appeal is received, regardless of whether the claims administrator has all of the information necessary to decide the appeal. If you want to provide the claims administrator with more time, in addition to the applicable time period, to make a determination after the appeal is received, you may voluntarily agree to an extension by contacting the claims administrator.

To assist in the preparation of your appeal, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your initial claim, as noted below. However, a request for documentation does not extend the time period allowed for you to file an appeal.

To obtain a copy of the claim file and other documents or records the claims administrator may have related to your claim, send your written request to the applicable claims administrator at the address noted in the table below. Your request must include your name, the patient's name (if different), the Wells Fargo group policy number, the individual member ID number, date of service, service provider, and what documents you are requesting.

Claims administrator	Address
UnitedHealthcare	UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130
Anthem Blue Cross Blue Shield	Anthem Blue Cross Blue Shield PO Box 60009 Los Angeles, CA 90060
Aetna	Aetna Attn: National Account CRT PO Box 14463 Lexington, KY 40512
Express Scripts	Express Scripts Attn: Commercial Claims PO Box 14711 Lexington, KY 40512-4711
Delta Dental	Delta Dental of Minnesota PO Box 30416 Lansing, MI 48909
Vision Service Plan (VSP)	VSP PO Box 2350 Rancho Cordova, CA 95741
HealthEquity	HealthEquity Claims Department PO Box 14053 Lexington, KY 40512

The applicable SPD is stated in this *Benefits Book* (to determine which chapters comprise the SPD for your plan, see the "Summary Plan Descriptions for each benefit plan" section in "Chapter 1: Eligibility, Enrollment and More"). If you want a copy of the plan document or a print version of the SPD mailed to you, send your written request to the plan administrator by U.S. mail (or overnight delivery such as UPS or FedEx) to:

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

Your written request must identify whether you are requesting a plan document or SPD and must include the Wells Fargo employee's name, Wells Fargo Employee ID number, the plan name, and calendar year or the date of service of the claim. If you wish for an authorized representative to request and receive a copy of the SPD or plan document on your behalf, an authorization for representation statement must be submitted with the request for the SPD or plan document (see the "Authorizing a representative" section on page A-12 for more information).

You may also request assistance in filing your appeal from your state's consumer assistance program or ombudsman, if applicable. To determine if your state has such resources, refer to the Centers for Medicare and Medicaid Services website at https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/#statelisting or call the Department of Labor Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA (3272).

Information needed for the appeal

Submit the following information with your appeal:

- Patient's name, date of birth, and relationship to the participant or employee
- Wells Fargo group number and individual member number
- Service provider's name
- For pre-service, urgent care, or concurrent care claim appeals, the diagnosis and the treatment or service for which approval is being requested
- For post-service appeals, the dates of service, claim number, or both
- An explanation of why you are appealing and your desired resolution
- Written testimony, comments, documents, medical records, or other information to provide clarity or support the appeal (for example, Explanation of Benefits statements, physician statements, previous correspondence, authorization notices, bills, and research)

Refer to the contact tables on the following pages for the location to send your appeal.

Contacts for urgent care claim and concurrent care claim appeals

Benefit option	Contact
UnitedHealthcare administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	UnitedHealthcare 1-800-842-9722 For urgent care claim appeals, specifically state that the appeal is an urgent care claim appeal. For prescription drug claim appeals, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.
Anthem Blue Cross Blue Shield administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	Anthem Blue Cross Blue Shield • By phone: 1-866-418-7749 • By fax: 1-877-876-4992 For urgent care claim appeals, specifically state that the appeal is an urgent care claim appeal. For prescription drug claim appeals, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.
Aetna administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	Aetna • By phone: 1-877-320-4577 • By fax: 1-859-425-3379 For urgent care claim appeals, specifically state that the appeal is an urgent care claim appeal. For prescription drug claim appeals, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.
Express Scripts administered prescription drug benefit: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	• Urgent Care Claim appeal – Your physician must submit the urgent care claim appeal request by calling 1-800-753-2851. – If you have questions, call customer service at 1-855-388-0352. • Nonurgent or Concurrent Care Claim appeals Express Scripts Attn: Clinical Appeals Department PO Box 66588 St. Louis, MO 63166-6588 Fax: 1-877-852-4070
Fully insured medical plans (including the insured Kaiser medical plan options and UnitedHealthcare Global — Expatriate Insurance)	For information, refer to your Evidence of Coverage, Certificate of Coverage, Summary Plan Description, or similar documentation provided directly from or made available to you by the insurer.
Delta Dental: • **Standard** • **Enhanced**	Not applicable. For pretreatment estimates, see "Chapter 3: Dental Plan."
Vision Service Plan (VSP)	Not applicable.
• **Health Reimbursement Account (HRA) claims** • **Flexible spending accounts** – **Full-Purpose Health Care FSA** – **Limited Dental/Vision FSA** **Note:** Appeals for benefits under the Day Care FSA are not governed by the claims and appeals procedures set forth in this appendix because the Day Care FSA is not governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA) and does not provide for medical care. For more information, refer to "Chapter 6: Day Care Flexible Spending Account."	Not applicable.

Contacts for pre- and post-service claim appeals

Benefit option	Address
UnitedHealthcare administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	UnitedHealthcare Appeals PO Box 740816 Atlanta, GA 30374-0816 For prescription drug claim appeals, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.
Anthem Blue Cross Blue Shield administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	Anthem Blue Cross Blue Shield Appeals PO Box 105568 Atlanta, GA 30348-5568 For prescription drug claim appeals, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.
Aetna administered: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	Aetna Attn: National Account CRT PO Box 14463 Lexington, KY 40512 For prescription drug claim appeals, refer to the information in the row titled "Express Scripts administered prescription drug benefit:" below.
Express Scripts administered prescription drug benefit: • **Copay Plan with HRA** • **Higher Use Plan with HSA** • **Lower Use Plan with HSA** • **Narrow Network Plan with HSA** • **Narrow Network Copay Plan** • **Flex HDHP**	• Pre-Service Claim appeal Express Scripts Attn: Clinical Appeals Department PO Box 66588 St. Louis, MO 63166-6588 Fax: 1-877-852-4070 • Post-Service Claim appeal Express Scripts Attn: Administrative Appeals Department PO Box 66587 St. Louis, MO 63166-6587 Fax: 1-877-328-9660
Fully insured medical plans (including the insured Kaiser medical plan options and UnitedHealthcare Global — Expatriate Insurance)	For information, refer to your Evidence of Coverage, Certificate of Coverage, Summary Plan Description, or similar documentation provided directly from or made available to you by the insurer.
Delta Dental: • **Standard** • **Enhanced**	Delta Dental of Minnesota PO Box 30416 Lansing, MI 48909
Vision Service Plan (VSP)	Vision Service Plan Attn: Claim Appeals PO Box 2350 Rancho Cordova, CA 95741
• **Health Reimbursement Account (HRA) claims under the Copay Plan with HRA** • **Flexible Spending Accounts:** – **Full-Purpose Health Care FSA** – **Limited Dental/Vision FSA** **Note:** Appeals for benefits under the Day Care FSA are not governed by the claims and appeals procedures set forth in this appendix because the Day Care FSA is not governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA) and does not provide for medical care. For more information, refer to "Chapter 6: Day Care Flexible Spending Account."	HealthEquity Claims Appeal Board PO Box 34700 Louisville, KY 40232 Fax: 1-866-843-2219

The internal appeal review and determination

The review of your claim on appeal will take into consideration all comments, documents, and other information submitted by you without regard to whether such information was submitted or considered in the initial benefit determination. The review on appeal will not defer to the initial benefit determination, and it will not be conducted by the same individual or individuals who made the initial adverse benefit determination or their subordinates.

For medical claims, the claims administrator will provide to you, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided (to give you a reasonable opportunity to respond prior to that date). After you receive the information, if you feel there is a need, you may submit additional information to the claims administrator for final consideration in the review process.

If the issue on appeal is based in whole or in part on a medical judgment, the individual or individuals responsible for the review must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional may not be an individual who was consulted in connection with the initial adverse benefit determination nor the subordinate of such individual.

The claims administrator will send you a written notice of the final internal appeal decision. The claims administrator may also provide you with verbal notice if your urgent care claim appeal is denied in whole or in part, but written notice will be furnished not later than three days after the verbal notice.

Regardless of the type of claim, a notice of an adverse benefit determination on appeal will be provided in written or electronic form and will provide the following information:

- The specific reason or reasons for the adverse determination
- Reference to the specific plan provisions on which the determination is based
- A statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records, and other information relevant to the claim, including the name of any health care professional consulted for the appeal review (if applicable)
- A statement regarding your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal
- If applicable, a statement indicating the internal rule, guideline, or protocol that was relied upon to make the adverse determination and that a copy of such rule, guideline, or protocol will be provided free of charge to you upon request
- If the adverse determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request
- For medical claims, your determination will also include:
  - Information sufficient to identify the claim involved
  - An explanation of any external review procedure
- Any additional information required under applicable law

For the dental and vision plan options and the Full-Purpose Health Care FSA, Limited Dental/Vision FSA, and the Health Reimbursement Account, the claims administrator's appeal determination is the final determination.

For the medical plan benefit options, participants may have the option to file for an external review. If there is no external review option available to you, the claims administrator's appeal determination is the final determination.

External reviews — appeals for medical claims only

External reviews

The external review process for medical claim appeals applies only to an adverse benefit determination under the Health Plan that involves medical judgment, as determined by the external reviewer. All other adverse benefit determinations, including a denial, reduction, or a failure to provide payment for a benefit based on a determination that you fail to meet the requirements for eligibility under the terms of the Health Plan, are not eligible for the external review process. For an adverse benefit determination involving a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time), refer to the "Appealing an adverse benefit determination — rescission of coverage" section on page A-19. If the claims administrator issued a final internal adverse benefit determination in response to your internal appeal and that determination was based on medical judgment, or if you have otherwise exhausted the internal claims and appeals process for a claim involving medical judgment, you have the right to request an external review under the following:

- UnitedHealthcare administered:
  - Copay Plan with HRA*
  - Higher Use Plan with HSA*
  - Lower Use Plan with HSA*
  - Narrow Network Plan with HSA
  - Narrow Network Copay Plan
  - Flex HDHP*
- Anthem Blue Cross Blue Shield administered:
  - Copay Plan with HRA*
  - Higher Use Plan with HSA*
  - Lower Use Plan with HSA*
  - Narrow Network Plan with HSA
  - Narrow Network Copay Plan
  - Flex HDHP*
- Aetna administered:
  - Copay Plan with HRA*
  - Higher Use Plan with HSA*
  - Lower Use Plan with HSA*
  - Narrow Network Plan with HSA
  - Narrow Network Copay Plan
  - Flex HDHP*
- Express Scripts administered prescription drug benefit:
  - Copay Plan with HRA*
  - Higher Use Plan with HSA*
  - Lower Use Plan with HSA*
  - Narrow Network Plan with HSA
  - Narrow Network Copay Plan
  - Flex HDHP*

* Including Out of Area coverage.

Your final internal adverse benefit determination notice from the claims administrator will describe the medical plan benefit option's external review procedure.

In general, if you are eligible to request an external review:

- You have four months to file your request for external review after receipt of the final internal adverse benefit determination.
- Your request for external review must be filed with the claims administrator.
- The claims administrator has five days to complete a preliminary review to confirm that:
  - The claimant is or was covered under the plan at the time the health care item or service was requested or provided.
  - The adverse benefit determination or the final adverse benefit determination did not relate to the claimant's failure to meet the requirements for eligibility under the plan.
  - The claimant has exhausted the plan's internal appeal process unless the claimant is otherwise not required to exhaust the process before requesting external review.
  - The claimant has provided all the information and forms required to process the external review.
  - Any other requirements of applicable law to file an external review have been satisfied.
- The claims administrator will send out an acknowledgment notice to you within one business day of the preliminary review.
  - If the request for external review is incomplete, the notice will describe the information or materials needed to make the request complete; you must refile your external review request with complete information within 48 hours or within the original four-month filing period, whichever is later.
  - If the request is not eligible for external review, the notification will include the reasons it was not eligible and your right to contact the Department of Labor's Employee Benefits Security Administration regarding such matters.
- The claims administrator must assign the eligible file to an independent review organization (IRO) accredited by URAC or other similar nationally recognized accrediting organization in accordance with the Patient Protection and Affordable Care Act and applicable regulations.

- The claims administrator will provide the full file to the IRO within five days of assigning the case to it.
- The IRO will send acknowledgment to you that it has been assigned to review your appeal and may offer you the opportunity to present additional information.
- The IRO will review the following types of information and documents received on a timely basis without regard to any previous decisions or conclusions:
  - Your medical records
  - Your attending health care professional's recommendation
  - Reports from appropriate health care professionals and other documents submitted by the plan, claimant, or provider
  - The terms of the plan under which you have coverage
  - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, or national or professional medical societies, boards, and associations
  - The IRO's clinical reviewer's opinion
  - The plan's applicable clinical review criteria, unless the criteria are inconsistent with the terms of the plan or with applicable law
- The IRO will issue written notice of the final external review decision to both you and the claims administrator as described under the "External review determinations" section on this page.

Expedited external reviews

If you have a medical condition that meets the requirements for an urgent care claim or if the final internal adverse benefit determination concerns admission, availability of care, continued stay, or health care item or service for which you received emergency services and you have not yet been discharged, you may be eligible for an expedited external review.

The difference between an external review and an expedited external review is the time frame allowed for making a determination as noted below.

External review determinations

The IRO will notify you and the claims administrator of the final external review determination:

- In writing within 45 days after the IRO receives the request for the standard external review
- Within 72 hours after the IRO receives the request for expedited external review

The determination will contain:

- A general description of the reason for the request
- Information sufficient to identify the claim at issue
- The date the IRO received the assignment to conduct the review
- The date of the IRO's decision
- A discussion of the principal reason or reasons for its decision, including references to the evidence and documentation reviewed and specific plan provisions and evidence-based standards used in reaching a decision
- A statement that the determination is binding on all parties except to the extent that other remedies may be available under state or federal law
- A statement that judicial review may be available to the claimant
- Current contact information, including phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHS Action section 2793

If the determination is favorable:

- And it is a pre-service appeal, the claims administrator will immediately issue the necessary authorization for the service.
- And it is a post-service appeal, the claims administrator will promptly process the claim for benefits.
- And services were rendered by a network provider, any benefit payment due will be made to the network provider directly.

You remain responsible for any applicable copayment, deductible, and coinsurance under the plan.

If the determination is favorable to you, the decision is binding on all parties except to the extent that other remedies may be available under state or federal law.

If the determination is not favorable to you, no additional benefits are due from the plan and you are responsible for any charges incurred for services received. No further review is available under the appeal process. However, you may have other remedies available under state or federal law, such as filing a lawsuit under Section 502(a) of ERISA.

The determination notice is binding on all parties.

Legal action

No legal action can be taken against any party with regard to a claim for benefits under the plans and benefit options to which the procedures in this appendix apply until the procedures described in the "Claims" section starting on page A-3 and the "Appealing an adverse benefit determination — claims" section starting on page A-11 have been exhausted. Any suit for benefits must be brought within one year from the date of the final internal appeal determination (or deemed final determination) or three years from the date the service or treatment was provided, whichever is earlier. Refer to the "Agent for service" section in "Appendix B: Important Notifications and Disclosures" for more information.

Appealing an adverse benefit determination — rescission of coverage

Coverage under a medical plan benefit option may be retroactively terminated if a participant (1) performs an act, practice, or omission that constitutes fraud, or (2) makes an intentional misrepresentation of material fact. Retroactive termination under these circumstances is considered a "rescission of coverage." Wells Fargo Corporate Benefits will provide the participant affected by the rescission of coverage at least 30 days' advance written notice of termination of coverage.

If an individual's coverage is retroactively terminated, then the individual may appeal the decision in accordance with the rescission appeal procedures described in the advance written notice. For purposes of these rescission appeal procedures, Wells Fargo Corporate Benefits shall be the named fiduciary and shall have discretionary authority to resolve factual issues and make final determinations with regard to appeals related to rescissions.

Claims determinations and dispute resolution with respect to out-of-network emergency care and eligible non-emergency services

When the claims administrator receives a claim from an out-of- network provider (including an out-of-network facility) for emergency care services (as defined in "Chapter 2: Medical Plans" in this *Benefits Book*) or eligible non-emergency services (as defined in "Chapter 2: Medical Plans" in this *Benefits Book*), the claims administrator will either notify the provider in writing of its denial of the claim or provide the benefit payment, as determined by the claims administrator, within 30 days of receiving a claim. No action is required by the provider if the provider agrees with the claims administrator's determination. If the out-of-network provider (including an out-of-network facility) disagrees with the claims administrator's determination, the provider may seek resolution of its objections by notifying the claims administrator of its desire to negotiate regarding the determination ("Open Negotiation Request") as soon as possible but no later than 30 days after receiving the claims administrator's determination ("Negotiation Request Period"). The provider waives its right to seek resolution of its objections if the provider fails to furnish the Open Negotiation Request with the claims administrator within the Negotiation Request Period. The claims administrator may also initiate an open negotiation by furnishing the provider with an Open Negotiation Request during the Negotiation Request Period. The Negotiation Request Period begins on the date the Open Negotiation Request is received by the non-requesting party and will last 30 days from that date. If the provider and the claims administrator are unable to reach agreement, either the provider or the claims administrator may, within four days after the Open Negotiation Period has ended, initiate the independent dispute resolution ("IDR") process described in Section 716 of ERISA. The plan administrator hereby delegates to the claims administrator all authority and discretion necessary to act on behalf of the plan with respect to any IDR. The IDR process is the exclusive method to resolve the amounts paid to providers for such services but the claims and appeals procedures described herein, however, will continue to apply to any determinations of cost-sharing (such as co-payments, coinsurance, and deductibles) as well as whether the services fall under the IDR process. Notwithstanding the foregoing, the IDR process will be administered in accordance with applicable law, regulations, and guidance.

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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, or your dependents if there is a loss of coverage under a Wells Fargo-sponsored 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 calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

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

- Narrow Network Plan with HSA administered by UnitedHealthcare
  - Charter Network in Illinois (Chicago area) requires a PCP designation upon enrollment in the plan. If you do not designate one, UnitedHealthcare will assign one to you.
  - Fairview ACO Core Network in Minnesota (Minneapolis/St. Paul area) recommends that you designate a PCP after you are enrolled and a representative from the network will contact you to ask who is your designated PCP.

- Narrow Network Copay Plan administered by UnitedHealthcare
  - Charter Network in Illinois (Chicago area) requires a PCP designation upon enrollment in the plan. If you do not designate one, UnitedHealthcare will assign one to you.
  - Fairview ACO Core Network in Minnesota (Minneapolis/St. Paul area) recommends that you designate a PCP after you are enrolled and a representative from the network will contact you to ask who is your designated PCP.

You have the right to designate any primary care provider who participates in the claims administrator's applicable network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, call UnitedHealthcare at 1-800-842-9722.

The following medical plans do not have any PCP requirements, but it is recommended that you establish a relationship with a PCP for continuity of care:

- Copay Plan with HRA
- Higher Use Plan with HSA
- Lower Use Plan with HSA
- Narrow Network Plan with HSA administered by Aetna
- Narrow Network Plan with HSA administered by Anthem BCBS
- Narrow Network Copay Plan administered by Aetna
- Narrow Network Copay Plan administered by Anthem BCBS
- Kaiser HMO
- HDHP Kaiser
- Kaiser POS Added Choice — Hawaii
- Flex HDHP

In addition, 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:** For the Narrow Network Plan with HSA, the Narrow 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, contact the applicable claims administrator. For contact information, see the plans listed 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 Street
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 the Director of Human Resources or the Director of Compensation and Benefits of Wells Fargo & Company, each of whom, acting individually or jointly, may take action as the plan administrator for the respective plan. 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 Street
Minneapolis, MN 55415

To contact the plan administrator, you may also call Employee Care 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 "Reviews of 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 through February 21, 2022, is:

Wells Fargo Bank, N.A.
MAC N9310-085
550 S 4th Street
Minneapolis, MN 55415

Effective February 22, 2022, the trustee for the plans 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 Fargo & 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 "Plan administrator" section starting on page B-4.

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 Director of Human Resources or Director of Compensation and Benefits 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.

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, Director of Human Resources, or Director of Compensation and Benefits 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-insured[2]) * Including Out of Area Coverage	537	**Medical** Aetna 1-877-320-4577 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]	Higher Use Plan with Health Savings Account (HSA)*[,3] (Self-insured[2]) * Including Out of Area Coverage	537	**Medical** Aetna 1-877-320-4577 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]	Lower Use Plan with Health Savings Account (HSA)*[,3] (Self-insured[2]) * Including Out of Area Coverage	537	**Medical** Aetna 1-877-320-4577 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]	Narrow Network Plan with Health Savings Account (HSA)[3] (Self-insured[2])	537	**Medical** Aetna 1-877-320-4577 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]	Narrow Network Copay Plan (Self-insured[2])	537	**Medical** Aetna 1-877-320-4577 Anthem Blue Cross Blue Shield 1-866-418-7749 UnitedHealthcare 1-800-842-9722 **Prescriptions** Express Scripts 1-855-388-0352

1. This plan will be known as the Wells Fargo & Company Health Plan (or the Health Plan) throughout this *Benefits Book*.
2. "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.

Plan name	Plan coverage option	Plan number	Service provider or insurer
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	Flexible High-Deductible Health Plan* (Self-insured[2]) * Including Out of Area Coverage	537	**Medical** Aetna 1-877-320-4577 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
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser Colorado (Insured[4])	537	Kaiser Permanente 1-800-632-9000
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser Georgia (Insured[4])	537	Kaiser Permanente 1-888-865-5813
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	POS Kaiser Added Choice — Hawaii (Insured[4])	537	Kaiser Hawaii 1-800-966-5955
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser Mid-Atlantic (Insured[4])	537	Kaiser Permanente D.C. area 301-468-6000 Outside D.C. area 1-800-777-7902
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser Northwest (Insured[4])	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 (Insured[4])	537	Kaiser Permanente 1-888-630-4636 Seattle 206-630-4636
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	High-Deductible Health Plan (HDHP) — Kaiser California (Insured[4])[3] (Northern and Southern California)	537	Kaiser Permanente 1-888-630-4636 Seattle 206-630-4636
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	High-Deductible Health Plan (HDHP) — Kaiser Colorado (Insured[4])[3]	537	Kaiser Permanente 1-800-632-9000
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	High-Deductible Health Plan (HDHP) — Kaiser Georgia (Insured[4])[3]	537	Kaiser Permanente 1-888-865-5813

1. This plan will be known as the Wells Fargo & Company Health Plan (or the Health Plan) throughout this *Benefits Book*.
2. "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.
4. "Insured" means benefits are fully insured and paid for by the insurer, which may be an HMO.

Plan name	Plan coverage option	Plan number	Service provider or insurer
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	High-Deductible Health Plan (HDHP) — Kaiser Mid-Atlantic (Insured[4])[3]	537	Kaiser Permanente D.C. area 301-468-6000 Outside D.C. area 1-800-777-7902
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	High-Deductible Health Plan (HDHP) — Kaiser Northwest (Insured[4])[3]	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]	High-Deductible Health Plan (HDHP) — Kaiser Washington (Insured[4])[3]	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-insured[2])	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-insured[2])	537	VSP 1-877-861-8352
Wells Fargo & Company International Plan	UnitedHealthcare Global — Expatriate Insurance (Insured[4])	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-insured[2])	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 (Insured[4])	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 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Life Insurance Plan	Dependent Term Life Insurance coverage (Insured[4])	506	Metropolitan Life Insurance Company (MetLife) Employee Care 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. "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.
4. "Insured" means benefits are fully insured and paid for by the insurer, which may be an HMO.

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 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Life Insurance Plan	Spouse/Partner Optional Term Life coverage (Insured[4])	506	Metropolitan Life Insurance Company (MetLife) Employee Care 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 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Accidental Death and Dismemberment Plan	Accidental Death and Dismemberment (AD&D) (Insured[4])	518	Metropolitan Life Insurance Company (MetLife) Employee Care 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Optional Accident Insurance Plan	Optional Accident Insurance Plan (Insured[4])	525	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Wells Fargo & Company Critical Illness Insurance Plan	Basic Critical Illness Insurance coverage (Insured[4])	524	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Wells Fargo & Company Critical Illness Insurance Plan	Optional Critical Illness Insurance coverage (Insured[4])	524	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320

4. "Insured" means benefits are fully insured and paid for by the insurer, which may be an HMO.

Appendix C: Health Savings Accounts

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Introduction

Please note that this appendix is included in the overall *Benefits Book* solely for your convenience. Although this appendix provides you with information regarding health savings accounts (HSAs), this appendix itself is not part of the official Summary Plan Description (SPD) for the Wells Fargo & Company Health Plan (or its benefit options, including the Higher Use Plan with Health Savings Account (HSA), Lower Use Plan with HSA (including applicable Out of Area options), or the Narrow Network Plan with Health Savings Account (HSA), and HDHP – Kaiser medical plans) or for any ERISA-covered employee benefit plans maintained by Wells Fargo & Company.

This appendix to the *Benefits Book* describes some key features of the HSA that you can open in conjunction with a high-deductible health plan, such as the Higher Use Plan with HSA and Lower Use Plan with HSA (including the applicable Out of Area options), or the Narrow Network Plan with HSA, and HDHP – Kaiser medical plans. In particular, and except as otherwise indicated, this appendix will address the HSA and not the associated high-deductible health plans. The Higher Use Plan with HSA, Lower Use Plan with HSA (including applicable Out of Area options), Narrow Network Plan with HSA, and HDHP – Kaiser medical plans are generally referred to in this appendix as "HSA-compatible medical plans."

Optum Bank provides certain HSA administrative services.

Wells Fargo does not insure the HSAs described in this appendix. It is Wells Fargo's intention to comply with U.S. Department of Labor guidance set forth in Field Assistance Bulletin Numbers 2004-01 and 2006-02, 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 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 of 1986. However, Wells Fargo will only support ongoing payroll deductions and provide funding of earned health and wellness dollars and an employer contribution (if eligibility criteria are met) for HSAs opened at Optum Bank.
- Wells Fargo does not make or influence the investment decisions with respect to funds contributed to an HSA.
- Wells Fargo does not represent that the HSA is an ERISA-covered employee benefit plan established or maintained by the employer.

An HSA is an individually owned account. Your HSA will continue to be your account, even if you leave Wells Fargo or change your medical coverage.

About the HSAs

An HSA is a tax-advantaged savings vehicle funded by you, your employer, or any other person on your behalf. An HSA can help you to cover, on a tax-free basis, qualified medical expenses that you pay out of pocket, such as deductibles or coinsurance. It may be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay nonmedical expenses; however, these amounts are subject to income tax and may be subject to an additional 20% tax. There are specific requirements for opening an HSA and making contributions to it as described later in this appendix, including enrolling in a high-deductible health plan.

Note: Tax references are at the federal level. Some state taxes may apply. Please consult a tax advisor.

What is an HSA?

An HSA is a tax-advantaged savings vehicle that participants in an HSA-compatible medical plan can use to pay for qualified medical expenses that they or their spouse and eligible dependents incur. After you lose eligibility to contribute to an HSA, you can continue to use your HSA to pay for expenses (even those incurred after the coverage stopped), but you will not be able to continue to make contributions.

HSA funds at Optum Bank:

- Accumulate in an interest-bearing deposit account and may be invested* once you reach the designated balance for your HSA
- Are portable
- Can be used to pay for qualified medical expenses tax-free or for nonmedical expenses on a taxable basis (are subject to income tax and may be subject to an additional 20% tax)

* INVESTMENT PRODUCTS: NOT FDIC INSURED, NO BANK GUARANTEE, MAY LOSE VALUE

Who is eligible to open and contribute to an HSA

Who is eligible to contribute to an HSA

You must be covered under one of the Wells Fargo-sponsored high-deductible health plans to contribute to an HSA. Eligibility to participate in the HSA-compatible medical plans is described in "Chapter 1: Eligibility, Enrollment, and More" in this *Benefits Book*.

You cannot contribute to an HSA if:

- You are covered under a non-HSA-compatible medical plan. Note that coverage under a "general purpose" health care flexible spending account (FSA) or health reimbursement account (HRA) through Wells Fargo or your spouse's employer is disqualifying coverage. In addition, individuals covered as dependents under a parent's "general purpose" health care FSA or HRA are not eligible to contribute to an HSA. A "general purpose" FSA or HRA covers more than dental, vision, preventive care, or post-deductible expenses.

  By contrast, coverage under a vision, dental, or other plan designated as permitted insurance by the IRS will not make you ineligible to contribute to an HSA. This means that coverage under a "limited purpose" FSA or HRA will not make you ineligible. A "limited purpose" FSA or HRA typically covers only dental, vision, preventive care, or post-deductible expenses.
- You are entitled to benefits under Medicare (that is, you are enrolled in Medicare).
- You are eligible to be claimed as a dependent on another person's tax return. Please note that generally a spouse is not considered a dependent for this purpose.
- You have received medical benefits from the Department of Veteran Affairs (VA) at any time during the previous three months (with an exception starting in 2016 for receipt of VA hospital care or medical services in connection with a service-related disability).
- You have received medical services at an Indian Health Service (IHS) facility at any time during the previous three months.

Note: You are responsible for determining if you are eligible to contribute to an HSA. Consult a tax advisor with questions.

How to open an HSA

If you enroll in one of the HSA-compatible medical plans sponsored by Wells Fargo and do not already have an HSA with Optum Bank, Wells Fargo will facilitate opening an HSA with Optum Bank for you. To open an HSA with Optum Bank, you must:

- Have a physical address as your home address.
- Provide Wells Fargo benefits with a home phone number.
- Appoint Wells Fargo & Company as your agent for account opening purposes as part of the online enrollment process.

Please be aware that HSAs are standard bank accounts and, as such, are subject to standard risk and customer due diligence screening both before being opened and during the life of the account. In some circumstances, Optum Bank may request additional information from you or Wells Fargo Corporate Benefits to open your HSA. If your Wells Fargo email address cannot receive external emails and your HSA has not been opened within 30 days of your benefits effective date, contact Optum Bank at 1-844-326-7967 to provide them with information necessary to complete the opening process. It is possible that Optum Bank could decline to open your HSA or could close your HSA. You will receive additional information from Optum Bank once they have opened your HSA.

Contributions

Contribution limits

The contribution limits for individual and family high-deductible health plan coverage are set by federal law.

- For the 2022 tax year, the maximum HSA contribution is:
  - $3,650 for people with individual coverage
  - $7,300 for people with coverage other than individual
- If you are age 55 or older, you may contribute an additional $1,000 per year to your HSA.

Any contribution that is made to your HSA by Wells Fargo counts toward the maximum HSA annual amount as set by federal law. Because Wells Fargo may contribute to an HSA through an employer contribution and you may also have the opportunity to earn health and wellness dollars, the Wells Fargo maximum HSA employee annual payroll contribution amounts for 2022 vary by compensation category. They are:

Total eligible compensation less than $45,000 year

- $2,350 You only
- $4,700 You + spouse or domestic partner
- $6,000 You + children
- $4,700 You + spouse or domestic partner + children

Total eligible compensation $45,000 to $100,000

- $2,600 You only
- $5,200 You + spouse or domestic partner
- $6,250 You + children
- $5,200 You + spouse or domestic partner + children

Total eligible compensation greater than $100,000

- $2,850 You only
- $5,700 You + spouse or domestic partner
- $6,500 You + children
- $5,700 You + spouse or domestic partner + children

For more information about eligible compensation, see the description on pages page C-6 and C-7.

These Wells Fargo maximum employee annual payroll contribution amounts will apply to you even if you're not eligible for, or do not receive, health and wellness dollars or an employer contribution. You may contribute to Optum Bank directly any difference between (1) the annual HSA contribution maximum and (2) the sum of the employer contribution, your pre-tax contributions, and your wellness incentive contributions to the HSA.

For information on making contributions to an HSA outside of payroll, refer to the "Contributing through Optum Bank" section on page C-7 of this appendix.

For more information about the maximum limits set by law, see the IRS website at www.irs.gov.

Your personal contribution limit may be lower than the maximum contribution limits listed above. Contribution limit rules are complex and should be carefully considered. For example, any employer contribution will count toward your maximum. It is also important to note that contribution limits are generally prorated if you are only eligible to contribute to an HSA for part of the year. However, if you become HSA-eligible midyear and are still eligible for an HSA on December 1 of that year, you may be allowed to contribute the maximum amount set by law for that year as long as you remain HSA-eligible during a 13-month "testing period" (beginning with the December of the year of the midyear enrollment and ending at the end of the following December). If you do not satisfy the testing period, you will face tax consequences. Consult a tax advisor to determine how midyear eligibility changes affect your contribution limit.

Note: Amounts that exceed your personal contribution maximum are not tax-deductible and will be subject to a 6% excise tax. This excise tax can be avoided if you withdraw the excess contribution (and net income attributable to such contribution) before the last day for filing your federal income tax return for the year (generally April 15 of the following year).

If you have contributed amounts in excess of the allowable maximum contribution, please call Optum Bank Customer Care at 1-844-326-7967.

Wells Fargo does not monitor whether you have exceeded your personal contribution limit. You are solely responsible for monitoring your personal contribution limit. Consult a tax advisor with questions.

Making payroll contributions

You can make contributions to your HSA through payroll deductions on a before-tax basis. You can make an HSA contribution election during your designated enrollment period or the Annual Benefits Enrollment period. You can also change your HSA contribution election anytime throughout the year through Direct Access on Workday. Once you elect your annual HSA payroll contribution, your total payroll contribution election will be divided by the number of remaining pay periods for the year (until you reach the maximum allowable amounts, if applicable). You cannot designate differing HSA employee payroll contributions for each paycheck.

Former employees in their severance eligibility period can continue to make HSA contributions through pre-tax payroll deduction.

Note: If coverage under an HSA-compatible medical plan terminates, no further payroll contributions may be made to your HSA.

Catch-up contributions

If you are age 55 or older during the 2022 calendar year and are otherwise eligible to contribute to an HSA, you can make an additional $1,000 payroll contribution on a before-tax basis. This contribution is often referred to as a "catch-up contribution." If you elect to make a catch-up contribution through payroll deduction, the amount will be divided by the number of remaining pay periods.

Full-Purpose Health Care FSA grace period

Important: If you were enrolled in the 2021 Full-Purpose Health Care Flexible Spending Account (FSA) and had a balance in that account on December 31, 2021, you **cannot** contribute to your HSA until April 1, 2022. That means that neither you nor Wells Fargo can make contributions toward your HSA, including both earned health and wellness dollars and the employer contribution, until April 1, 2022.

Health and wellness contributions

You and your covered spouse or domestic partner may be able to earn health and wellness dollars to be deposited to your HSA after completing certain health- and wellness-related activities. For more information, refer to the "Health and wellness activities" section in "Chapter 2: Medical Plans."

Employer HSA contribution

Eligibility

Regular and fixed term employees (as well as former regular and fixed term employees in their severance eligibility period) who meet all of the following conditions will be eligible to receive an employer HSA contribution in 2022:

- You must be eligible for and elect medical coverage under one of the Wells Fargo-sponsored HSA-compatible medical plans during your initial election period for medical coverage effective in 2022 and must be enrolled in one of the HSA-compatible medical plans on the date the employer HSA contribution is made.
- You must have an open HSA with Optum Bank on the date the employer HSA contribution is made and must not have exceeded the maximum annual HSA contribution limit for 2022.
- Your eligible compensation must be $100,000.00 or less (see the "Eligible compensation for employer HSA contributions" section on page C-6).

An employee's initial election period varies depending on when the employee was first eligible to make an election for 2022 Wells Fargo-sponsored HSA-compatible medical coverage:

- For employees who became eligible to participate in Wells Fargo-sponsored medical coverage on or before December 1, 2021, the initial election period was the annual benefits enrollment period that took place in the fourth quarter of 2021.
- For employees who became eligible to participate in Wells Fargo-sponsored medical coverage after December 1, 2021, the initial election period is the employee's initial designated enrollment period.
- If an intern or flexible employee becomes a regular or fixed term employee, the initial election period is the 30 days following the effective date of the regular or fixed term employment status.
- If an employee declines Wells Fargo-sponsored medical coverage during annual benefits enrollment, the initial designated enrollment period, or the 30 days after an employment status change (as applicable), and elects to enroll in Wells Fargo-sponsored HSA-compatible medical coverage during the year due to a Qualified Event or special enrollment right, the initial election period is the 60-days following the date of the Qualified Event or special enrollment right.

Timing of contribution

The employer HSA contribution will be paid in a lump sum in accordance with the following, based on the benefits eligibility date, and subject to the eligibility rules described in the "Eligibility" section on page C-5:

- If you are a regular or fixed term employee (or a former employee in your severance eligibility period) who is enrolled in one of the HSA-compatible medical plans effective January 1, 2022, your employer HSA contribution will be made in January 2022 to your HSA with Optum Bank provided that you did not have a Full-Purpose Health Care Spending Account as of December 31, 2021, or had a zero balance in your Full-Purpose Health Care Spending Account as of December 31, 2021. If you had a remaining balance in your Full-Purpose Health Care Spending Account as of December 31, 2021, the employer HSA contribution will be made to your HSA with Optum Bank in April 2022. If you had a remaining balance in your Full-Purpose Health Care Spending Account as of December 31, 2021 and you are in your severance eligibility period, you must still be in your severance eligibility through April 2022 in order to receive the employer HSA contribution in April 2022.
- If you are a regular or fixed term employee (or a former employee in your severance eligibility period) who newly enrolls in one of the HSA-compatible medical plans after January 1, 2022, your employer HSA contribution will be made approximately 30 days following your benefits eligibility date.

The effective date of a regular or fixed term employee's (or former employees in their severance eligibility period) HSA-compatible medical plan coverage that corresponds to the election made during the employee's initial election period is considered the employee's benefits eligibility date. For example, a regular or fixed term employee who elects HSA-compatible medical plan coverage for the 2022 plan year during annual benefits enrollment would have a benefits eligibility date of January 1, 2022, while a regular or fixed term employee who is newly hired on April 15, 2022 and elects HSA-compatible medical plan coverage during their initial designated enrollment period would have a benefits eligibility date of June 1, 2022.

Amount of employer HSA contribution

The employer HSA contribution will not be increased or reduced if your HSA-compatible medical plan coverage level in effect on your benefits eligibility date changes prior to the date the employer HSA contribution is made. The employer HSA contribution counts toward your maximum HSA contribution limit for 2022 (see the "Contribution limits" section on page C-4 for more information). The amount of the employer HSA contribution for eligible employees will be based on your eligible compensation (see the "Eligible compensation for employer HSA contributions" section below), benefits eligibility date, and coverage level, as described in the chart below.

Eligible compensation	Benefits eligibility date	Coverage level is "you only" or "you + children"	Coverage level is "you + spouse or domestic partner" or "you + spouse or domestic partner + children"
Less than $45,000.00	January 1, 2022 to March 31, 2022	$500.00	$1,000.00
	April 1, 2022 to June 30, 2022	$375.00	$750.00
	July 1, 2022 to September 30, 2022	$250.00	$500.00
	October 1, 2022 to December 31, 2022	$125.00	$250.00
$45,000.00 to $100,000.00	January 1, 2022 to March 31, 2022	$250.00	$500.00
	April 1, 2022 to June 30, 2022	$187.50	$375.00
	July 1, 2022 to September 30, 2022	$125.00	$250.00
	October 1, 2022 to December 31, 2022	$62.50	$125.00

Eligible compensation for employer HSA contributions

A regular or fixed term employee's (or former employees in their severance eligibility period) eligible compensation for purposes of the employer HSA contribution will be determined based on the job classification code (job class code) for the employee's position (or most recent position of former employees in their severance eligibility period) on the Wells Fargo Human Capital Management System (HCMS) as of October 1, 2021.

Find your eligible compensation on the HCMS by navigating to View profile → Actions → Benefits → View Benefits Annual Rate.

Job Class Code 2

Most positions at Wells Fargo are job class code 2. For job class code 2 positions, if you are a salaried employee, eligible compensation is defined as your annual base salary as of October 1, 2021, plus eligible incentive compensation, if any, paid to you in the twelve (12) months prior to October 1, 2021. If you are an hourly employee, annual base salary is determined by multiplying your standard hours on HCMS by your hourly wage and annualizing the result. If you are in a job class code 2 position and you are hired (or rehired) or become newly eligible

for Wells Fargo-sponsored medical coverage on or after October 1, 2021, eligible compensation is determined based on salary and payroll information on HCMS as of your date of hire (or rehire) or date of eligibility for Wells Fargo-sponsored medical coverage, as applicable, plus eligible incentive compensation (if any) paid to you in the prior twelve (12) months. Annual base salary does not include some forms of compensation, such as overtime pay, shift differentials, incentives, bonuses (including but not limited to hiring, incentive, and retention bonuses), commissions, noncash awards, and perquisites such as parking or auto allowance or commuter subsidies. Eligible incentive compensation includes commissions, bonuses, and other earnings indicated on HCMS as eligible incentive compensation.

Job Class Codes 1 and 5 – Mortgage Consultant Participant and Variable Incentive Compensation (VIC) positions

For both job class codes 1 and 5, eligible compensation is determined by annualizing your earnings based on eligible incentive compensation paid to you in the twelve (12) months prior to October 1, 2021. Eligible incentive compensation includes commissions, bonuses, and other earnings indicated on HCMS as eligible incentive compensation. If you are in a job class code 1 or 5 position and you are hired (or rehired) or become newly eligible for Wells Fargo-sponsored medical coverage on or after October 1, 2021, eligible compensation is determined based on salary and payroll information on HCMS as of your date of hire (or rehire) or date of eligibility for Wells Fargo-sponsored medical coverage, as applicable, plus eligible incentive compensation (if any) paid to you in the prior twelve (12) months.

Contributing through Optum Bank

In addition to making contributions via payroll deduction, there is another way to contribute to your HSA through Optum Bank to meet your personal contribution limit. You can contribute money directly to your HSA at any time through Optum Bank. To make a one-time contribution or schedule recurring contributions to your HSA, you may access your account by signing on to Optum Bank at https://www.optumbank.com.

All funds placed into your HSA are owned and controlled by you and subject to the terms and conditions of the Custodial and Deposit Agreement provided by Optum Bank.

Qualified medical expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs, including annual deductibles and coinsurance under an HSA-compatible medical plan. You may also use your HSA funds to pay for medical care that is not covered under an HSA-compatible medical plan but is eligible under Section 213(d) of the Internal Revenue Code of 1986 ("the Code"), as amended from time to time. Expenses that are for "medical care" under Section 213(d) of the Code are "qualified medical expenses." HSA funds used for such purposes are not subject to income or excise taxes.

Qualified medical expenses only include your and your eligible dependents' medical expenses, meaning your spouse and any other individuals whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Code.

Effective January 1, 2020, and as a result of the CARES Act, certain over-the-counter drugs and medicines, like aspirin and pain relievers, are eligible for payment or reimbursement from an HSA. Menstrual care products are also considered qualified medical expenses for HSAs.

Examples of what constitutes "qualified medical expenses" are available in IRS Publication 502, which is available from any regional IRS office or the IRS website. They are also available at https://www.optumbank.com. Note that Publication 502 lists expenses that are deductible — which aren't necessarily the same as expenses that are HSA-eligible. For example, although taxpayers may deduct health insurance premiums on their tax returns if certain requirements are met, reimbursement of such premiums through an HSA is restricted. HSAs may only reimburse limited categories of insurance premiums on a tax-favored basis (for example, premiums for COBRA coverage).

Important

Be sure to keep your receipts and medical records. If these records verify that you paid qualified medical expenses using your HSA, you can exclude these HSA distributions from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified medical expenses, you may need to report the distribution as taxable income on your tax return. Wells Fargo does not verify that distributions from your HSA are for qualified medical expenses. Consult a tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Wells Fargo is not responsible for maintaining receipts and is not responsible if you use HSA funds for nonqualified medical expenses.

Using the HSA for nonqualified expenses

A nonqualified medical expense is generally one that is not eligible under Section 213(d) of the Code. Any funds used from your HSA to pay for nonqualified expenses will be subject to income tax and a 20% additional tax unless an exception applies to the additional tax (that is, your death, your disability, or your attainment of age 65). In general, you may not use your HSA to pay for health insurance premiums without incurring an income tax and a penalty tax. (You may use your HSA to pay for COBRA, Medicare, and certain other premiums.)

Additional information about the HSA

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will carry over to the following year. If your employment terminates for any reason or your enrollment in an HSA-compatible medical plan ends, you will continue to own and control the funds in your HSA, whether or not you elect COBRA coverage for the HSA-compatible medical plan, as described in this *Benefits Book*.

If you choose to roll over the HSA funds to another HSA trustee or custodian, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds.

You will need to make sure to update any personal home address changes after your initial enrollment with Optum Bank. You are responsible for notifying Optum Bank directly of any changes and for all maintenance of the HSA.

Wells Fargo pays the monthly service fee for the HSA as long as you are enrolled in a Wells Fargo HSA-compatible medical plan. The HSA must be opened through the Wells Fargo-designated HSA administrator, Optum Bank. Wells Fargo does not pay other fees associated with the HSA, as outlined in the Schedule of Fees and Custodial and Deposit Agreement provided in your welcome kit or available on the Optum Bank website at https://www.optumbank.com. You will be responsible for the monthly service fee and all other fees for your HSA if you are no longer enrolled in a Wells Fargo HSA-compatible medical plan.

You can obtain additional information about HSA online at https://www.irs.gov/publications/p969/ar02.html#en_US_publink1000204020 or at https://www.optumbank.com. You may also contact a tax advisor. Optum Bank Customer Care can be contacted at 1-844-326-7967.

Note: The tax rules for HSAs are complex. This appendix only describes some of the rules. You should review information provided by Optum Bank and the IRS, as well as the Code provisions for HSAs. Wells Fargo does not provide tax advice, and you may want to consult with a tax advisor. All tax references are at the federal level; state taxes may vary.

Appendix D: Leaves of Absence and Your Benefits

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General information

Wells Fargo offers various types of leaves of absence. Depending on the type of leave of absence taken, you may remain eligible to participate in the Wells Fargo-sponsored benefit plans described in this *Benefits Book*. However, the way you pay for your benefits premiums and contributions may change depending on whether you receive certain forms of income replacement during your leave. This appendix describes when your eligibility to participate in benefits continues during a leave of absence and how you will pay for benefits while on the leave. However, it's important to note that the specific plan provisions for applicable benefit plans, which are described in the individual chapters of this *Benefits Book*, govern the eligibility for and administration of benefits.

For the purposes of this appendix, the types of leave of absence options available are defined and described in the *Service Now* articles under *HR Services and Support*.

- Your leave of absence may be protected under the Family Medical Leave Act (FMLA). If your leave is protected by FMLA, please refer to the "Family Medical Leave Act (FMLA)" section on page D-5 for applicable information.
- Your leave of absence may be protected by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If your leave is protected by USERRA, please refer to the "Uniformed Services Employment and Reemployment Rights Act (USERRA)" section on page D-5 for applicable information.

Refer to the *Service Now* articles under *HR Services and Support* for more information about the various types of leaves offered by Wells Fargo. You may also call Lincoln Financial, the leaves and claims administrator, at 1-866-213-2937. To file a claim, you may access the Lincoln Financial Portal at www.MyLincolnPortal.com. **Note:** The leave of absence programs contained in *Service Now* do not govern Wells Fargo-sponsored benefit plans.

The information in this paragraph is for informational purposes only and is not part of any Summary Plan Description. Other programs not described in this *Benefits Book* may be impacted by your leave of absence (such as the Commuter Benefit Program). Refer to Teamworks for details and any actions you may be required to take. The policies related to any such programs do not govern Wells Fargo-sponsored benefit plans described in this *Benefits Book*.

Eligibility to participate in benefits during leaves of absence

Subject to exceptions described below, eligibility for regular and fixed term employees to participate in the following voluntary benefit options generally continues during a leave of absence as long as you continue to pay the required applicable contribution or premium:

- Medical
- Dental
- Vision
- Full-Purpose Health Care FSA*
- Limited Dental/Vision FSA*
- Day Care FSA*
- Life Insurance (Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverages)
- Accidental Death and Dismemberment
- Optional Long-Term Disability
- Legal Services
- Optional Accident Insurance
- Optional Critical Illness Insurance

* Participation in the Full-Purpose Health Care FSA, Limited Dental/Vision FSA, and Day Care FSA will not extend beyond the plan year in which the leave began, unless you make a new benefit election during the Annual Benefits Enrollment period (see the "Annual Benefits Enrollment" section on page D-3).

Subject to exceptions described below, eligibility to participate in the following company paid benefit options generally continues during a leave of absence:

- Basic Term Life Insurance
- Short-Term Disability
- Short-Term Disability Top-Up
- Basic Long-Term Disability
- Basic Critical Illness Insurance

Note: Eligibility for flexible employees to participate in the following voluntary benefit option: medical, generally continues during an approved leave of absence as long as you continue to pay the required applicable contribution or premium.

Eligibility to participate in the following benefit options terminates for certain leaves

Regardless of the type of leave, Business Travel Accident coverage terminates when your leave of absence begins.

If you are on a Personal Leave, Job Search Leave, Preferential Hiring Leave, Military Leave, or unpaid Administrative Leave, eligibility to participate or be enrolled in the following benefit options terminates:

- Basic Long-Term Disability
- Optional Long-Term Disability

If you are on a Job Search Leave, Preferential Hiring Leave, Military Leave, or unpaid Administrative Leave, eligibility to participate or be enrolled in the following benefit option terminates:

- Short-Term Disability
- Short-Term Disability Top-Up

If you have questions or to obtain more information, contact Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, 3, 1.

Annual Benefits Enrollment

When you are on a leave of absence, you may generally make benefit elections (subject to all enrollment provisions of the plans and benefit options) during the Annual Benefits Enrollment period for the upcoming plan year. Benefits elected during the Annual Benefits Enrollment period and corresponding costs for coverage become effective January 1 of the following year. However, if you have elected a benefit option during the Annual Benefits Enrollment period that has an "actively at work" requirement and you are on a leave of absence on January 1, your coverage effective date will be delayed until you return to work in a regular or fixed term position. See the applicable chapter in this *Benefits Book* to determine if the "actively at work" or delayed effective date apply to the benefit options you have elected.

If you have elected participation in a flexible spending account and you are on a leave of absence on January 1 without recognized sources of income replacement, your contributions, including any applicable missed contributions for the current plan year, will begin when you return to work in a regular or fixed term position. If you owe any back contributions, you will experience double deductions until all missed contributions have been taken, or the end of year, whichever comes first. However, the annual elected contribution amount made for your Full-Purpose Health Care FSA or Limited Dental/Vision FSA election will be available to you as of January 1. For more information, see "Chapter 5: Health Care Flexible Spending Account Plan (Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)." For information on the Day Care FSA, refer to "Chapter 6: Day Care Flexible Spending Account."

Paying for your benefits while on a leave

Leaves with certain recognized sources of income replacement

If you are using PTO or if you make a claim for certain Wells Fargo income replacement benefits (such as Parental Leave, Critical Caregiving Leave, short-term disability benefits under the Wells Fargo & Company Short-Term Disability Plan or Wells Fargo & Company Short-Term Disability Top-Up Plan, or benefits under the Texas Injury Benefits Plan) and your claim is approved, all of your applicable contributions and premiums for elected benefits (for regular and fixed term employees) will automatically be deducted from your income replacement benefit.

If the amount of income replacement you receive is not sufficient to cover past due and/or current benefit deductions, then the currently due benefit deductions and contributions are taken first. If, after this, there is not sufficient income replacement to cover the past due benefit deductions and contributions, then past due deductions will not be taken and will become arrearage.

If another entity provides income replacement, such as Workers' Compensation or long-term disability benefits (including through the Wells Fargo & Company Long-Term Disability Plan for an approved claim), that income replacement is not recognized for the purposes of benefit deductions. See the "Leaves without recognized sources of income replacement" section below for more information on how to pay for continued benefits.

Leaves without recognized sources of income replacement

If you are on a leave of absence with no income replacement benefits you will be placed in direct billing. See the "Direct billing process" section below for more information.

Direct billing process

Under the direct billing process, you will receive a billing statement each month for the cost of your coverage and you will be required to make direct payments by the due date.

Payments for medical, dental, and vision coverage

Application of payments submitted during the direct billing process will follow a hierarchy giving precedence to all medical premiums. Payments received by the due date are applied in the following order:

- Medical coverage
  - Payments are first applied to past due contributions or premiums and then to currently due contributions or premiums.

- Dental coverage
  - Payments are first applied to past due contributions or premiums and then to currently due contributions or premiums.
- Vision coverage
  - Payments are first applied to past due contributions or premiums and then to currently due contributions or premiums.

Payments for all other benefits coverage

After payments have been applied to medical, dental, and vision coverage as noted above, payments are then applied to all other benefits in the order they are billed on the billing statement, generally: Optional Long-Term Disability, Spouse/Partner Term Life, Optional Term Life, Optional Critical Illness Insurance, Optional Accident Insurance, Dependent Term Life, Legal Services coverage, and Accidental Death and Dismemberment, for each pay period missed.

For any benefit for which payment is not received in full within 60 days of the original billing date, coverage may end on the last day of the month for which the last full payment was received (partial payment may be reallocated to other benefit amounts due).

For example, if your billing statement is for medical, dental, and legal services coverage, and at the end of 60 days from the original billing date, your payment is only enough to cover all medical premiums (oldest to current), your dental benefits coverage would end on the last day of the month in which the balance was paid in full. Legal services coverage would end on the last day of the month for which the balance was paid in full.

Note: Contributions to your Full-Purpose Health Care FSA, Limited Dental/Vision FSA, Day Care FSA, or Health Savings Account are not billed through the direct billing process. Nevertheless, your eligibility to continue participation in the applicable FSA continues for the duration of your leave (or to the end of the current plan year if your leave continues from one year into the next) and you remain the owner of your health savings account funds even though contributions are not being taken. If you participate in the Day Care FSA, generally, you cannot claim expenses incurred during your leave. To be eligible for reimbursement under the Day Care FSA, the day care expenses must be incurred so you can work or look for work. For more information on flexible spending accounts, see "Chapter 5: Health Care Flexible Spending Account Plan (Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)" or "Chapter 6: Day Care Flexible Spending Account."

Termination of benefits coverage for nonpayment

If you fail to make the required payments as described in the "Direct billing process" section starting on page D-3, you will receive a final notice explaining the total amount due and the date your coverage will end if payment is not received. If your coverage terminates due to nonpayment, you may lose eligibility for COBRA continuation (only for benefit options subject to COBRA).

If your benefits coverage is terminated due to nonpayment, reinstatement options for the benefit plans vary when you return to work. For information, see the "Returning from a leave of absence" section on this page.

For information regarding the impact of a lapse of coverage under your benefit options, please see the applicable chapter in this *Benefits Book*.

Returning from a leave of absence

If you stayed current in paying for your benefits while you were on a leave of absence and you return to your regular work schedule in a regular, fixed term or flexible position immediately following your leave, your benefit elections (for which you are still eligible) will continue upon your return to work and the corresponding cost for coverage will be deducted from your pay, including any back contributions or premiums owed, unless your coverage was terminated for nonpayment. If you owe any back contributions or premiums, you will experience double deductions until all missed contributions or premiums have been taken.

If your leave type resulted in termination of coverage for Short-Term Disability, Short-Term Disability Top-Up, or Long-Term Disability upon the commencement of your leave, when you return to work in a regular or fixed term position immediately following your leave, your enrollment in the Short-Term Disability Plan, Short-Term Disability Top-Up Plan, and Basic Long-Term Disability coverage under the Long-Term Disability Plan may be reinstated. However, reinstatement of Optional Long-Term Disability coverage depends on the length of your leave; see "Chapter 12: Long-Term Disability Plan" for more information.

If your benefits coverage was terminated due to nonpayment while you were on a leave of absence, and you return to work during the same plan year, generally, you will have to wait until the next Annual Benefits Enrollment period to make benefit elections (subject to all enrollment provisions of the plans and benefit options). Please note the following:

- Regular and fixed term employees may reenroll in medical, dental, vision, or legal services coverage if you experience an applicable special enrollment right or Qualified Event. Flexible employees may reenroll in the Flex HDHP plan (or POS Kaiser Added Choice — Hawaii, if a resident of Hawaii) if you experience an applicable special enrollment right or Qualified Event. For more information, see the "Special enrollment rights" section and the "Qualified Events" section in "Chapter 1: Eligibility, Enrollment, and More."

- For the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, if you return to work during the same plan year in a regular or fixed term position, your payroll deductions will begin again and if you owe any back contributions, you will experience double deductions until all missed contributions have been taken, or the end of year, whichever comes first. For more information on the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, see "Chapter 5: Health Care Flexible Spending Account Plan (Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)."
- For the Day Care FSA, if you return to work during the same plan year in a regular or fixed term position, your payroll deductions will begin again and if you owe any back contributions, you will experience double deductions until all missed contributions have been taken, or the end of year, whichever comes first. For more information on the Day Care FSA, see "Chapter 6: Day Care Flexible Spending Account."
- If you want to reenroll for Optional Term Life Insurance coverage, Spouse/Partner Optional Term Life Insurance coverage, or Dependent Term Life Insurance coverage, you will be required to submit a completed Statement of Health form through the late enrollment process. Refer to the applicable chapter in this *Benefits Book* for more information on the late enrollment process.
- For information about reinstatement of Optional Long-Term Disability, see "Chapter 12: Long-Term Disability Plan."

Different requirements may apply when you return from a leave of absence that is protected under the Family Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Termination of employment while on a leave of absence

Generally, if you have been on a leave of absence for 24 months, your employment will end. In some cases, employment may be terminated before the end of 24 months.

See the "When coverage ends" section in "Chapter 1: Eligibility, Enrollment, and More" for more information about benefits coverage termination.

You will receive information about how to continue applicable medical, dental, or vision coverage and Health Care FSA participation under COBRA within a couple of weeks. For more information on COBRA coverage, refer to "Appendix E: Continuing Coverage Under COBRA."

Refer to the applicable chapter in this *Benefits Book* for information on how to continue any applicable life insurance, accidental death and dismemberment, or legal services coverage.

To be eligible to continue coverage after termination, you must have made all payments for benefits coverage while you were on leave.

Family Medical Leave Act (FMLA)

Certain leaves of absence may be protected under the Family Medical Leave Act (FMLA). If your leave is protected under FMLA, Wells Fargo will continue to maintain your benefits coverage and provide for applicable reinstatement of coverage when you return to work to the extent required by FMLA.

For more information on FMLA protection, refer to the *Service Now* articles related to FMLA or call the leaves and claims administrator at 1-866-213-2937. Please note leave of absence programs contained in *Service Now* do not govern Wells Fargo-sponsored benefit plans.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Benefits coverage while you are on Military Leave

Medical, dental, vision, legal services, accidental death and dismemberment, optional critical illness insurance, optional accident insurance, and life insurance coverage can continue through the first 24 months of your approved Military Leave to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), provided that you continue to pay your contributions or premiums and have not voluntarily dropped your coverage. You may also continue your Full-Purpose Health Care FSA or your Limited Dental/Vision FSA for the remainder of the current plan year.

Note: Your eligibility for coverage under the Short-Term Disability Plan, Short-Term Disability Top-Up Plan, and the Long-Term Disability Plan (both Basic LTD and Optional LTD) terminates upon the commencement of an approved Military Leave.

You may elect to drop your benefit coverages upon going on an approved Military Leave. To do so, call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, 2, 3, during the period 30 days prior to the start of your Military Leave through 60 days following the start of your Military Leave. If you choose to voluntarily drop your coverage, it will become effective the first of the month following the date of the event or the first of the month following the date you call Employee Care, whichever is later, as long as you have called within the specified time period.

Paying for benefits coverage while you are on Military Leave

Generally, the process for paying for your continued benefits follows the process explained in the "Paying for your benefits while on a leave" section starting on page D-3. Coverage stops if you stop paying your contributions or premiums or cancel coverage as allowed under USERRA. However, there are additional nuances specific to a USERRA-protected leave as described below.

Benefits coverage and returning from Military Leave

Returning to work within the job reinstatement period

Regardless of whether or not you continued your benefits while on approved Military Leave, depending on your employment classification, upon your reemployment after Military Leave, you can request to:

1. Have the benefits that you were enrolled in prior to your leave reinstated or
2. Make new benefit elections for the benefit options listed below.

Note: Interns and flexible employees are only eligible to elect medical coverage.

You must have been on leave greater than 31 days for either of these options to apply. Please call Employee Care at **1-877-HRWELLS (1-877-479-3557), option 2, 2, 3,** within 60 days of your reemployment date to make your request.

As specified above, the following benefit options may be elected as new benefits upon your return from Military Leave in a regular or fixed term position:

- Medical
  - If you change medical plans mid-year or enroll in a medical plan mid-year, you will be required to meet the applicable full year annual deductible and out-of-pocket maximum under the newly elected plan option. For more information on mid-year enrollments, see the applicable section in "Chapter 2: Medical Plans."

If you are considering electing coverage in a high-deductible health plan with a corresponding health care savings account (HSA), please review the "Who is eligible to contribute to an HSA" section on page C-3 and other information within "Appendix C: Health Savings Accounts" before making your election. Appendix C is solely for your convenience and is not part of any Summary Plan Description for any ERISA-covered employee benefit plans maintained by Wells Fargo & Company.

- Dental
- Vision
- Full-Purpose Health Care FSA or Limited Dental/Vision FSA, as applicable (Mid-year election changes from the Full-Purpose FSA to the Limited Dental/Vision FSA or vice versa are not allowed. For more information, review the "Some rules to know" section on page 5-4.)
- Day Care FSA
- Optional Critical Illness Insurance
- Optional Accident Insurance
- Accidental Death & Dismemberment Plan
- Legal Services Plan
- Life Insurance
  - Optional Term Life — enroll for the first time at 1x covered pay[1] or increase previously elected coverage by 1x covered pay[1,2]
  - Spouse/Domestic Partner Optional Term Life — enroll for the first time at $25,000[1] or increase previously elected coverage by $25,000[1,2]
  - Dependent Term Life — enroll

1. If you want to enroll at a higher level of coverage, you must follow the process described under the "Late enrollment" section in "Chapter 7: Life Insurance Plan" in this *Benefits Book*.
2. Your previously elected coverage must have been in effect at the time your Military Leave began.

Your benefit elections will be effective upon your reemployment provided you enroll or reenroll within 60 days of your reemployment date.

IMPORTANT: If you continued your benefits coverage while on Military Leave and return to work within 24 months and do not make new benefit elections upon your reemployment, you will continue to be enrolled in the benefit options you paid for while on Military Leave.

Different processes apply for reinstatement or enrollment in disability coverage upon your reemployment as described below:

- For regular and fixed term employees, your enrollment in the Short-Term Disability Plan, Short-Term Disability Top-Up Plan, and Basic Long-Term Disability coverage under the Long-Term Disability Plan will automatically be reinstated at the same level of coverage you had before your leave began. Coverage will be effective upon your reemployment.
- If you were on a Military Leave for six months or less, the Optional Long-Term Disability coverage you had before your leave began will automatically be reinstated if you return to work as a regular or fixed term employee. Coverage will be effective upon your reemployment. If you don't want your coverage reinstated, you must call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, 2, 3, within 60 days of your reemployment date.

- If you were on a Military Leave for greater than six months, Optional Long-Term Disability coverage is not automatically reinstated; regular and fixed term employees must call Employee Care within 60 days of your return to work to request reinstatement of the Optional Long-Term Disability coverage you had before your leave began. Coverage will be effective upon your reemployment.
- If you did not have Optional Long-Term Disability coverage before your leave began and want to elect it upon your reemployment as a regular or fixed term employee, see the "Late enrollment" section on page 12-4 in "Chapter 12: Long-Term Disability Plan" for more information.

Returning to work after the job reinstatement period

If your coverage lapses or terminates due to nonpayment while you are on Military Leave and you return to work after the applicable job reinstatement period has expired, you must generally wait until the next Annual Benefits Enrollment period to reenroll, unless you have an applicable special enrollment right or a Qualified Event. For more information, see the "Special enrollment rights" section and the "Qualified Events" section in "Chapter 1: Eligibility, Enrollment, and More."

For more information

For more information on USERRA, refer to the *Service Now* articles under *HR Services and Support* or call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, 3, 5. Please note that leave of absence programs contained in *Service Now* do not govern Wells Fargo-sponsored benefit plans.

For more information about the Wells Fargo-sponsored benefit plans, including the impact of a lapse of coverage under your benefit options, see the chapter that applies to the benefit options in this *Benefits Book*.

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Appendix E: Continuing Coverage Under COBRA

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Notice regarding state continuation of coverage **E-12**

Notice to individuals covered under a fully insured California health plan E-12

Federal law requires that the Wells Fargo group health plans give qualified beneficiaries the opportunity to continue their health care coverage when there is a qualifying event that causes a loss of coverage under the applicable Wells Fargo group health plan (the Plan). As used in the "COBRA general notice" section below and in the "COBRA administrative information" section starting on page E-5, the term "group health plan" means the medical (including the prescription drug benefit), dental, and vision benefit options under the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents), the Wells Fargo & Company Health Care Flexible Spending Account Plan, and the Wells Fargo & Company International Plan. Depending on the type of qualifying event, qualified beneficiaries can include Wells Fargo employees covered under a group health plan, their covered spouse or domestic partner, and covered dependent children. In this section, Wells Fargo employees are referred to as "you" or "participants."

COBRA general notice

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the applicable Summary Plan Description including the "COBRA administrative information" section starting on page E-5 or contact the COBRA Administrator. The COBRA Administrator is BenefitConnect™ | COBRA.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees, or you may qualify for a special Medicare enrollment period if you are Medicare eligible and you are losing active group health coverage.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of certain life events. These events are called "qualifying events." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your covered spouse or covered domestic partner, and your covered dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. A child born to the covered employee qualified beneficiary during the COBRA period is also a qualified beneficiary if properly enrolled. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The covered employee will become a qualified beneficiary if coverage is lost because of one of the following qualifying events:

- The covered employee's hours of employment are reduced
- The covered employee has a change in employment classification from flexible to regular or fixed term
- The covered employee's employment ends for any reason other than gross misconduct

A covered spouse or covered domestic partner of an employee will become a qualified beneficiary if coverage is lost because of one of the following qualifying events:

- The covered employee dies
- The covered employee's hours of employment are reduced
- The covered employee has a change in employment classification from flexible to regular or fixed term
- The covered employee's employment ends for any reason other than their gross misconduct
- The covered employee and covered spouse divorce or legally separate, or the covered employee and covered domestic partner terminate their domestic partnership or civil union

A covered dependent child will become a qualified beneficiary if coverage is lost because of one of the following qualifying events:

- The covered employee dies
- The covered employee's hours of employment are reduced
- The covered employee has a change in employment classification from flexible to regular or fixed term
- The covered employee's employment ends for any reason other than their gross misconduct
- The covered employee and spouse divorce or legally separate (applies to the Wells Fargo employee's stepchildren only) or the covered employee and domestic partner terminate their domestic partnership or civil union (for covered children of the domestic partner only)
- The child stops being eligible for coverage under the Plan as a "dependent child"

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. The employer must notify the COBRA Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment*
- Death of the employee

For all other primary qualifying events (divorce or legal separation of the employee and a spouse, termination of a domestic partnership or civil union of the employee and partner, or a dependent child's losing eligibility for coverage as a dependent child), you must notify Employee Care within 60 days after the date coverage would end by calling 1-877-HRWELLS (1-877-479-3557), option 2.

* If pursuant to a severance agreement with Wells Fargo (or an affiliate) you are eligible to receive severance pay (other than a lump sum payment) for a period of time (the "severance eligibility period"), your active coverage may be extended during the severance eligibility period. In that case, your COBRA continuation coverage may not begin until after you have exhausted the severance eligibility period. Failure to pay the active premiums during the severance eligibility period will terminate your right to COBRA continuation coverage.

How is COBRA continuation coverage provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse or domestic partner, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If a covered qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, each qualified beneficiary enrolled in COBRA may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

An 11-month extension of coverage may be available if a qualified beneficiary meets both of the following criteria:

- The qualified beneficiary is determined to be disabled by the Social Security Administration at some time before the 60th day of COBRA continuation coverage.
- The qualified beneficiary notifies BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) of the Social Security Administration's disability determination and provides a copy of the Social Security disability award letter to BenefitConnect™ | COBRA before the end of the initial 18-month COBRA continuation period and within 60 days of the later of:
  - The date on which the qualifying event — termination of employment or reduction of hours — occurs
  - The date coverage is lost (or would be lost) as a result of the qualifying event
  - The date of the disability determination by the Social Security Administration

Failure to timely provide notice of a disability and a copy of Social Security's disability determination may affect the right to extend the period of COBRA continuation coverage.

To provide a copy of the Social Security disability award letter showing the date Social Security determined you to be disabled to BenefitConnect™ | COBRA, send the documentation to:

BenefitConnect | COBRA
DEPT: COBRAUS
PO Box 981914
El Paso, TX 79998

Each qualified beneficiary who has elected COBRA continuation coverage will be entitled to the 11-month disability extension if the previously listed criteria are met. The rates paid for COBRA coverage during the 11-month disability extension period are equal to 150% of the premium.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you or your dependent must notify BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) within 60 days of the Social Security Administration's determination.

- If the qualified beneficiary is determined to no longer be disabled within the original COBRA extension period, they will no longer be eligible for the 11-month extension of COBRA coverage.
- If the qualified beneficiary is determined to no longer be disabled within the 11-month extension period, their COBRA continuation coverage will end the first of the month following 30 days after the date of the final SSA determination that the individual is no longer disabled. You must timely provide notification of the SSA determination to BenefitConnect™ | COBRA.

Second qualifying event extension of 18-month or 29-month period of continuation coverage. If a qualified beneficiary experiences another qualifying event during the 18 or 29 months of COBRA continuation coverage, qualified beneficiaries can get up to a total of 36 months (measured from the original qualifying event) if the COBRA Administrator is properly notified about the second qualifying event. This extension may be available to the spouse or domestic partner and any dependent children getting COBRA continuation coverage if one of the following second qualifying events occurs during the 18- or 29-month period:

- The qualified beneficiary former employee dies
- The qualified beneficiary former employee and qualified beneficiary spouse divorce or legally separate (or there is a termination of a domestic partnership or civil union)
- A qualified beneficiary dependent child stops being eligible under the Plan as a dependent child

This extension of COBRA continuation coverage is only available if the second qualifying event would have caused the spouse or domestic partner or dependent child to lose coverage under the Plan had it been the first qualifying event.

To receive this second qualifying event extension of COBRA continuation coverage, BenefitConnect™ | COBRA must be notified of the second qualifying event within 60 days after the second qualifying event occurs to maintain extension rights under COBRA. To notify BenefitConnect™ | COBRA of the second qualifying event, call 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at https://cobra.ehr.com. Failure to notify BenefitConnect™ | COBRA within 60 days of the second qualifying event will make the qualified beneficiary ineligible for the extension rights under COBRA.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP),[1] or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, you may have an 8-month special enrollment period[2] to sign up for Medicare Part A or B when coverage provided by virtue of your or a family member's current employment status ends (i.e. when your active coverage ends). This special enrollment period begins on the earlier of the following:

- The month after your employment ends
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare when first eligible or during the special enrollment period, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then later lose coverage, you will not qualify for a Medicare special enrollment period solely because you are losing coverage under COBRA. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. **NOTE:** If you are eligible for but not enrolled in Medicare, the Plan may pay benefits (to the extent permitted by law) as if you are enrolled in Medicare.

For more information about Medicare, visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator: BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). Representatives are available from Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time. You may also access https://cobra.ehr.com.

For more information about your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **healthcare.gov**.

1. https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program

2. https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Keep your Plan informed of address changes

To protect your family's rights, let Employee Care know about any changes in addresses of family members by calling 1-877-HRWELLS (1-877-479-3557), option 2. Once enrolled in COBRA, let BenefitConnect™ | COBRA know about any changes in addresses of family members (see "Plan contact information" below). You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Plan contact information

For more information about COBRA continuation coverage and the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents), the Wells Fargo & Company Health Care Flexible Spending Account Plan, and the Wells Fargo & Company International Plan:

- Visit https://cobra.ehr.com
- Call the COBRA Administrator, BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only)
- Send a written request to:

  BenefitConnect | COBRA
  DEPT: COBRAUS
  PO Box 981914
  El Paso, TX 79998

Important information about payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election. If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of each month. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for periodic payments

Although periodic payments are due on the dates stated above, you'll be given a grace period of 30 days after the first day of the month to make each periodic payment.

COBRA administrative information

General information

COBRA continuation coverage is the same coverage that the Wells Fargo group health plans give to other similarly situated participants and beneficiaries who are not receiving COBRA continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under a Wells Fargo group health plan as other plan participants, including Annual Benefits Enrollment and special enrollment rights.

Coverage and eligibility rights

Plan coverage may be continued through COBRA continuation coverage only for those individuals who are "qualified beneficiaries." Qualified beneficiaries include any of the following who were covered under the plan on the day immediately preceding the qualifying event (the specific primary qualifying events identified in the "Primary qualifying events" table on page E-6 that cause a loss of coverage):

- The covered employee
- The covered spouse or domestic partner
- The covered dependent child

Each qualified beneficiary has the right to elect coverage regardless of what the employee or other covered dependents choose.

New dependent eligibility and rights

Newly eligible dependents may be added to coverage after the initial COBRA qualifying event, provided that they meet the eligibility requirements and are enrolled within 60 days of becoming eligible. However, except for the covered employee's newborn or newly adopted children, dependents added after the qualifying event are not qualified beneficiaries and do not have separate and independent COBRA rights. Children born to or adopted by a covered participant after the COBRA period begins and who are timely enrolled are qualified beneficiaries.

Adding a new dependent

To enroll newly eligible dependents in COBRA, you must notify BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at https://cobra.ehr.com within 60 days of the dependent becoming eligible. Most changes in coverage are effective the first of the month following the date of the event or the date you notify BenefitConnect™ | COBRA, whichever is later. **Note:** The timely medical plan enrollment of your dependent gained through birth, adoption, or placement for adoption will be made retroactively to the date of birth, adoption, or placement for adoption.

Other qualified COBRA beneficiaries

Children of an employee who are receiving benefits under the medical plan pursuant to a Qualified Medical Child Support Order (QMCSO) also qualify as qualified beneficiaries if they were covered on the day preceding a qualifying event.

Primary qualifying events

The following qualifying events give qualified beneficiaries the opportunity to continue their health care coverage when the event causes a loss of coverage:

Covered Wells Fargo employee	Covered spouse or domestic partner	Covered dependent children
• Reduction in hours of employment (such as employment classification from regular or fixed term to flexible) • Change in employment classification from flexible to regular or fixed term • Termination of employment (including retirement)	• The covered employee's reduction in hours (such as employment classification from regular or fixed term to flexible) • The covered employee has a change in employment classification from flexible to regular or fixed term • The covered employee's termination of employment (including retirement) • The covered employee and covered spouse divorce or legally separate, or the covered employee and covered domestic partner terminate their domestic partnership or civil union • The covered employee dies	• The covered employee's reduction in hours (such as employment classification from regular or fixed term to flexible) • The covered employee has a change in employment classification from flexible to regular or fixed term • The covered employee's termination of employment (including retirement) • The covered employee and spouse divorce or legally separate (for the Wells Fargo employee's covered stepchildren only), or the covered employee and domestic partner terminate their domestic partnership or civil union (for covered children of domestic partner only) • The covered employee dies • Loss of dependent child status

Your notification responsibilities — primary qualifying events

Wells Fargo will have knowledge of the covered employee's termination of employment (including retirement), reduction of hours, or change in employment classification. However, you, your covered spouse or domestic partner, or covered dependent child must call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, when one of the following events occurs:

- A divorce, legal separation, or termination of domestic partnership or civil union.

  In the event of divorce, notify Employee Care of this event separately from any qualified domestic relations order (QDRO) that you may submit for retirement plans.
- A child loses dependent status. **Note:** Employee Care will know when a covered dependent child becomes ineligible due to reaching the maximum age allowed under the plan (age 26 based on the child's birthdate). The child will be deemed ineligible at the end of the month in which the child turns age 26 regardless of any separate notification requirements for which you are responsible.
- The covered employee dies.

Notice must be provided to Employee Care within 60 days of the date coverage would be lost due to one of the qualifying events. If you, your covered spouse or domestic partner, or your covered dependent child, wait longer than 60 days to notify Employee Care of the qualifying event, COBRA continuation rights may not apply.

When Employee Care is notified that one of these events has occurred and you have confirmed the mailing address of the qualified beneficiary, the COBRA administrator will notify the appropriate parties of their COBRA continuation coverage rights. **Note:** A notice to your spouse or domestic partner is treated as notice to any covered dependents who reside with the spouse or domestic partner.

Length of COBRA continuation coverage

The maximum length of COBRA continuation coverage for qualified beneficiaries under each qualifying event is as follows:

Qualifying event	Maximum extension and cost
Reduction in hours of employment (such as employment classification change from regular or fixed term to flexible).	18 months, full cost[1, 2, 3, 4, 5, 6]
Change in employment classification from flexible to regular or fixed term.	18 months, full cost[1, 2, 3, 4, 5, 6]
A covered dependent child stops being eligible for coverage under the Plan as a "dependent child."	36 months, full cost[1, 4, 5]
The covered employee and spouse divorce or legally separate, or the covered employee and domestic partner terminate their domestic partnership or civil union.[7]	36 months, full cost[1, 4, 5]
The covered employee dies.	36 months: 12 months paid by Wells Fargo, 24 months at full cost[1, 4, 5, 8]
The covered employee's employment terminates (including retirement).	18 months, full cost[1, 2, 3, 4, 5, 6]

1. Full cost is the total cost to the plan, including employer contributions, to provide coverage to similarly situated individuals, and an additional 2%.
2. If you or your dependent is disabled within the first 18 months of COBRA continuation coverage, the maximum extension will be 11 months (for a total of 29 months of COBRA continuation coverage) if you have provided the proper notice. Refer to the "Disability extension of 18-month period of continuation coverage" on page E-3 for more information. **Note:** The rates paid for COBRA coverage during the extension period are equal to 150% of the premium.
3. If you have a secondary qualifying event after an initial qualifying event, you may be able to continue COBRA for an extended period of time (not to exceed a total of 36 months of COBRA continuation coverage).
4. Coverage may terminate before the end of the maximum extension as described in the "End of COBRA continuation coverage" section on page E-12.
5. Participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA can continue only through the end of the current plan year.
6. When the qualifying event is the end of your employment or reduction of your hours of employment, and you become entitled to Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you can last up to 36 months after the date of your Medicare entitlement. If you became entitled to Medicare benefits less than 18 months before the qualifying event, you or your covered dependent must notify BenefitConnect™ | COBRA of the Medicare entitlement and request the applicable extension of COBRA continuation coverage. You may be asked to provide proof of Medicare entitlement, such as a copy of the Medicare ID card. (**Note:** "Entitled" means you are enrolled in Medicare.)
7. If the legal separation, divorce, or termination of the domestic partnership or civil union occurs after coverage is voluntarily dropped by the employee for the spouse or domestic partner (but not to exceed one year), and it is determined in the Plan Administrator's sole discretion that the coverage was dropped in anticipation of a divorce or domestic partnership termination, the spouse or domestic partner may be eligible for COBRA continuation coverage. Once notified of legal separation, divorce, or termination of the domestic partnership or civil union (in accordance with the procedures outlined in the "Your notification responsibilities — primary qualifying events" section on page E-6), the plan administrator (or its designee) will determine whether the previous termination of coverage was "in anticipation of" the legal separation, divorce, or termination of the domestic partnership in accordance with the plan's internal policies and procedures. If the ex-spouse or former domestic partner is eligible for and elects COBRA continuation coverage, COBRA continuation coverage will begin on the first of the month following the date of legal separation, divorce, or termination of domestic partnership.
8. In the event of an employee's death, the first 12 months of COBRA continuation coverage for medical, dental, and vision benefit options (for the covered eligible dependent) under the Wells Fargo & Company Health Plan will be paid in full by Wells Fargo. Wells Fargo does not make any contributions to a flexible spending account, even during the first 12 months of COBRA.

The "Length of COBRA continuation coverage" table above shows the maximum period of COBRA continuation coverage available to qualified beneficiaries. The length of extended coverage under COBRA depends upon the qualifying event triggering eligibility, as illustrated in the table. COBRA continuation coverage will be terminated before the end of the maximum period as described in the "End of COBRA continuation coverage" section on page E-12.

Extending COBRA continuation coverage

If a qualified beneficiary elects COBRA continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary:

- Is disabled (see the "Disability extension of 18-month period of continuation coverage" section on page E-3 for more information)
- Experiences a second qualifying event (see the "Second qualifying event extension of 18-month or 29-month period of continuation coverage" section on page E-4 for more information)

You or your dependent must notify BenefitConnect™ | COBRA of a Social Security disability determination or second qualifying event to extend the period of COBRA continuation coverage. Call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of COBRA continuation coverage. For more information on notification timing, see the applicable section referenced above.

Electing COBRA continuation coverage

To elect COBRA continuation coverage, you must access https://cobra.ehr.com or call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) to make your COBRA continuation coverage election by the enrollment deadline provided in the COBRA Election Notice. If COBRA continuation coverage is not elected by this deadline, all rights to elect COBRA continuation coverage will end.

Each qualified beneficiary has a separate right to elect COBRA continuation coverage. For example, your spouse or domestic partner may elect COBRA continuation coverage even if you do not. COBRA continuation coverage may be elected for only one, several, or all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. You or your spouse or domestic partner can elect COBRA continuation coverage on behalf of all the qualified beneficiaries.

In considering whether to elect continuation coverage, you and your eligible dependents should take into account that there are special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's or domestic partner's employer) within 30 days after your group health coverage ends because of the qualifying event (listed above). You will also have the same special enrollment right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA election period

Qualified beneficiaries have until the later of the following time periods to elect COBRA continuation coverage:

- 60 days from the date of the COBRA Election Notice
- 60 days from the date coverage terminates in accordance with the Plan's terms

Your specific COBRA enrollment deadline will be communicated in your COBRA Election Notice.

Notification of your enrollment in COBRA continuation coverage will be sent to the applicable claims administrator only after your first payment is received and processed, if the payment was timely received.

If COBRA continuation coverage is not elected by the enrollment deadline, all rights to elect COBRA continuation coverage will end.

Summary of Benefits and corrections

The primary account holder for the COBRA continuation coverage will receive a letter confirming your COBRA enrollment after COBRA enrollment elections have been made, either after initial enrollment under COBRA or during Annual Benefits Enrollment. You may also confirm your COBRA enrollment elections online at https://cobra.ehr.com. If the enrollment information does not match the elections made, call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). If you are outside of the 60-day enrollment period or the Annual Benefits Enrollment change period, no corrections can be made to COBRA benefit enrollment elections.

Cost of COBRA continuation coverage

You and each qualified beneficiary will have to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary, with the exception of the Social Security disability extension, which may be 150% of the premium. The additional percentage is the administration fee permitted by law. The required payment for each COBRA continuation coverage period for each option is described in the COBRA Election Notice and is also available online at https://cobra.ehr.com.

Payment of COBRA continuation coverage

The costs and payment procedures for COBRA continuation coverage will be explained in the COBRA Election Notice sent to you and your covered dependents. Shortly after you enroll in COBRA coverage, you will receive a packet of COBRA payment coupons, with a coupon for each monthly payment due in the current plan year, that should be used to submit payments. However, after your first payment has been made, you may choose to pay for COBRA continuation coverage through one of the following options:

- Pay by one-time ACH payment. To make payments by one-time ACH payment, navigate to https://cobra.ehr.com or call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). You may use a one-time ACH payment for your first payment and any subsequent payments. If payment is made by one-time ACH payment, your payment is considered to be made on the date that the payment is submitted.
- Enroll in the Auto Pay program (direct debit payment) option following instructions in the COBRA Election Notice. You may enroll in Auto Pay online at https://cobra.ehr.com or by calling BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).
- Pay by check, cashier's check, or money order via U.S. mail with the applicable monthly payment coupon from the packet of COBRA payment coupons sent to you after you enrolled in COBRA (or following the COBRA Annual Benefits Enrollment period for the new year).
- Send payment using a bill paying service through your financial institution. Make sure to include your unique Customer ID, found on your COBRA Election Notice or payment coupon, when sending payments.

First payment for COBRA continuation coverage

You do not have to send any payment when you first elect COBRA continuation coverage. However, notification of enrollment in COBRA continuation coverage will be sent to the applicable claims administrator only after the first payment is received and processed, if the payment was timely received. You must make your first payment for COBRA continuation coverage by a one-time ACH payment, check, cashier's check, or money order no later than 45 days after the date you make your COBRA continuation coverage election. Your payment due date will be indicated on your applicable COBRA payment coupon.

If you are mailing your payment, it should be mailed to the address indicated in the COBRA Election Notice or on the COBRA payment coupons you receive following your election or any subsequent coverage change. When making your payment, include the applicable monthly COBRA payment coupon or reference your unique Customer ID found on your COBRA Election Notice. **Note: The first payment must be for all the months, from the COBRA coverage start date to the end of the current month.** COBRA continuation coverage is effective (retroactive to the date active coverage ended) only when you timely enroll with COBRA and make payment within 45 days of your COBRA election date.

If you do not make a COBRA payment on time, you will lose COBRA continuation coverage rights under the Wells Fargo group health plans.

Important notes

- You or your enrolled dependents are responsible for making sure that the amount of the first COBRA payment is correct. If you have questions concerning payment due, contact BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).
- Your first payment for COBRA continuation coverage is due within 45 days from the date you make your COBRA election even if you have not yet received your COBRA payment coupons. Include your unique Customer ID (found on your COBRA Election Notice) with your payment and send to one of the addresses noted below, depending on when you want your payment received.
- You should receive a packet of COBRA payment coupons, with a coupon for each monthly payment due in the current plan year, two weeks following the date you elect COBRA continuation coverage. If you do not receive the packet of COBRA payment coupons by this date, call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).
- Mail the required COBRA payment by regular U.S. mail with the applicable monthly COBRA payment coupon to:

  Wells Fargo
  PO Box 205896
  Dallas, TX 75320-5896

  Or you can send the required COBRA payment by overnight delivery to:

  Wells Fargo
  Lockbox Services 205896
  2975 Regent Blvd.
  Irving, TX 75063

- Pay by one-time ACH payment.

  To make payments by one-time ACH payment, navigate to https://cobra.ehr.com, or call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). If payment is made by one-time ACH payment, your payment is considered to be made on the date that the payment is submitted.
- Failure to submit the required COBRA payment by one of the methods listed above may result in a delay in payment processing and possible cancellation of your COBRA continuation coverage for nonpayment.
- Do not include any additional correspondence with your payment.

Monthly payments of COBRA continuation coverage

After you make your first COBRA payment, payments are due for each subsequent month by the first of the month for which you want coverage. The amount due for each month for each

enrolled qualified beneficiary is shown on the applicable monthly COBRA payment coupon. You should have received a packet of COBRA payment coupons, with a coupon for each monthly payment due in the current plan year, within two weeks following the date you elect COBRA continuation coverage. If you have not received the packet of COBRA payment coupons within this time period, call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).

You will not be billed for COBRA continuation coverage each month. You are responsible for making monthly payments by the due date.

To have your monthly COBRA payments deducted directly from your bank account, you may choose to enroll in the Auto Pay program. Enroll online at https://cobra.ehr.com or you may call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).

After enrolling in the Auto Pay program, payment for your monthly COBRA premiums will be deducted from the designated bank account on the first business day of the month. The total amount deducted will include the payment owed for the current month, as well as any outstanding balance owed in prior months.

If you have not enrolled in the Auto Pay program, subsequent payments must be sent to BenefitConnect™ | COBRA by a one-time ACH payment or regular U.S. mail and postmarked by the due date as indicated on the applicable monthly COBRA payment coupon. If you do not have a COBRA payment coupon, mail your payment along with your unique Customer ID found on your COBRA Election Notice. Alternatively, you can send your monthly payment with the COBRA payment coupon or unique Customer ID by overnight delivery to the following address:

Wells Fargo
Lockbox Services 205896
2975 Regent Blvd
Irving, TX 75063

All COBRA payments are due by the first of the month for which you want coverage.

If your COBRA payment is late, you have a 30-day grace period to make full payment as described in the "Grace periods for monthly payments" section starting on this page. This grace period does not apply to the first payment due.

Payments made or postmarked after the due date as indicated on the applicable monthly COBRA payment coupon will be deposited before a determination is made as to whether any such payment is timely made. Late payments received after the grace period will be refunded to you and will not extend your COBRA continuation coverage. Depositing of payments should not be construed as acceptance of payment in full.

If the payment is determined to not be timely made, coverage terminates retroactive to the last day of the last month for which full payment was received. **Once terminated, coverage cannot be reinstated.**

If you do not make a COBRA payment on time, you will lose COBRA continuation coverage rights under the Wells Fargo group health plans.

Grace periods for monthly payments

Although monthly payments must be made or postmarked by the due date indicated on the applicable monthly COBRA payment coupon, you will be given a 30-day grace period after this date to make each monthly payment. BenefitConnect™ | COBRA will mail you a COBRA premium reminder letter if you have an outstanding balance due after the applicable monthly due date has passed. This letter will indicate the outstanding balance due and the date payment must be made or postmarked in order for coverage to continue. The due date indicated in this letter will include the 30-day grace period. You are responsible for ensuring all payments are made and postmarked by the due date or by the end of the grace period.

COBRA continuation coverage will be provided for each month, as long as payment for that month is made or postmarked before the end of the grace period for that specific payment. It is important to note that the grace period does not apply to the first payment due. In addition, if the premium you send is insufficient by an insignificant amount (the lesser of 10% or $50), you will be permitted to cure that insufficiency within the next 30 days and not lose COBRA coverage.

If your required monthly payment is not made or postmarked by the due date as indicated on the applicable monthly COBRA payment coupon or within the grace period, you will lose all rights to COBRA continuation coverage under the Wells Fargo group health plans.

For example, the COBRA payment for coverage for the month of January is due and must be made or postmarked by January 1. However, if the payment is missed or delayed, the delinquent payment must be made or postmarked on or before January 31 to be considered timely made for the January coverage. If the payment is made or postmarked February 1 or after, it will not be applied to your continuation coverage and COBRA continuation coverage will end as of December 31.*

* Please note that all payments received will be deposited before a determination is made as to whether any such payment is timely made. Late payments will be refunded to you and will not extend your COBRA continuation coverage. Depositing of payments should not be construed as acceptance of payment in full.

Please remember that you should send the COBRA payment with the applicable monthly COBRA payment coupon. However, if you do not have the applicable monthly COBRA payment coupon, submit your payment with your unique Customer ID (found on your original COBRA Election Notice) to the address noted below. All payments for COBRA continuation coverage should be sent by U.S. mail to:

Wells Fargo
PO Box 205896
Dallas, TX 75320-5896

Or you can send payment by overnight delivery to:

Wells Fargo
Lockbox Services 205896
2975 Regent Blvd.
Irving, TX 75063

Changing COBRA continuation coverage

Whenever your status or that of a dependent changes, you must notify BenefitConnect™ | COBRA of the change within 60 days. COBRA continuation coverage may be modified based on plan rules if you experience a Qualified Event (for example, birth, marriage, legal separation, divorce, termination of a domestic partnership, or change in dependent eligibility). Refer to "Chapter 1: Eligibility, Enrollment, and More" in this *Benefits Book* for a complete list of Qualified Events. Premiums may be adjusted for coverage changes.

Adding a dependent to COBRA continuation coverage

Although you may add eligible dependents if you experience a Qualified Event, these dependents will generally not be qualified beneficiaries. If you experience a Qualified Event and wish to add a dependent to your COBRA continuation coverage, you must notify BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at https://cobra.ehr.com within 60 days of the Qualified Event.

Note: If a child is born to the covered participant or placed for adoption with the covered participant during the COBRA continuation period, and you wish to add the child to your COBRA continuation coverage, you must notify BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at https://cobra.ehr.com within 60 days of the birth or placement. If enrolled within 60 days of birth or adoption, the child will be a qualified beneficiary and their COBRA continuation period will be the same as yours (or the same that yours would have been). There may be a higher premium for this additional coverage.

Discontinuing your COBRA continuation coverage or removing a dependent from coverage

Certain events result in you or your dependent becoming ineligible for coverage before the maximum COBRA period is reached, requiring you to discontinue or to make a change to your COBRA continuation coverage election. You must notify BenefitConnect™ | COBRA immediately by calling 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at https://cobra.ehr.com if any of the following events occur:

- **You or your covered dependent obtains coverage under another group plan after your COBRA qualifying event.** Coverage will be terminated effective the first of the month following the date the individual obtained coverage under the other group plan or the date you notify BenefitConnect™ | COBRA, whichever is later. You are obligated to provide notice of the existence of the other coverage, and coverage may be terminated retroactively if notice is provided after the first of the month following the effective date of such other coverage.
- Legal separation, divorce, or termination of a domestic partnership or civil union, if you cover your spouse or domestic partner.*
- Your covered dependent child reaches age 26.*
- Your death.*

* See the "Second qualifying event extension of 18-month or 29-month period of continuation coverage" section starting on page E-4 for more information.

Premiums or contributions will continue to be taken and processed until you notify and provide any required documentation to BenefitConnect™ | COBRA. Claims incurred by you or a dependent after the end of the month in which coverage ends will be denied. If required documentation is not received by BenefitConnect™ | COBRA, you will be provided notice, after which coverage will terminate as of the date of loss of eligibility.

Voluntarily dropping COBRA continuation coverage

You may drop COBRA continuation coverage for yourself or any of your covered dependents at any time by calling BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).

Changes made to your COBRA continuation coverage will be effective the first of the month following the date you contact BenefitConnect™ | COBRA. You will be responsible for paying the full premium or contribution for your previous election or coverage level until the effective date of your change in coverage. For example, you are enrolled with You + Spouse COBRA medical coverage. You call BenefitConnect™ | COBRA on May 5 and request to drop your spouse from your COBRA medical coverage.

- Your spouse will be dropped from your COBRA medical coverage effective June 1.
- You must pay the You + Spouse COBRA medical premium through May 31.
- Effective June 1, you will pay the You Only COBRA medical premium.

Other changes

Any changes that Wells Fargo makes to the same coverage of similarly situated members will automatically be applied to your COBRA continuation coverage, such as an increase in premiums, change in plan provisions or plan processes, or a change to the coverage options available.

Coordination of COBRA continuation coverage

If you already have other group insurance or Medicare and elect COBRA continuation coverage under a Wells Fargo plan, your coverage will need to be coordinated. One plan will be considered primary and the other plan will be secondary. To determine which plan is primary, refer to your Summary Plan Descriptions from both plans. You must notify the claims administrator for the plan or plans in which you are enrolled if you have other coverage. Coordination of benefits information for the Wells Fargo-sponsored health plans is found in "Chapter 1: Eligibility, Enrollment, and More" in this *Benefits Book*.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. Additionally, if you are enrolled in Part A before you elect COBRA coverage and do not enroll in Part B, your COBRA coverage will reimburse your claims as if Part B were in place. For more information about Medicare, visit https://www.medicare.gov/medicare-and-you.

End of COBRA continuation coverage

If you or your dependents choose COBRA continuation coverage, it may be continued for the period of time indicated in the "Length of COBRA continuation coverage" table on page E-7. Whenever your status or that of a dependent changes, you must notify BenefitConnect™ | COBRA of the change within 60 days. (See the "Changing COBRA continuation coverage" section on page E-11 and the "Second qualifying event extension of 18-month or 29-month period of continuation coverage" on page E-4 for more information.)

However, coverage will end before the maximum extension date if any of the following situations occur:

- **Any required premium or contribution is not paid in full.** Coverage will be terminated retroactively to the end of the month for which full payment was made.
- **COBRA payments are not made or postmarked as of the due date and exceed the 30-day grace period.** Coverage will be terminated retroactively to the end of the month for which full payment was made.
- **Wells Fargo no longer provides group medical, dental, vision, Full-Purpose Health Care FSA, or Limited Dental/Vision FSA coverage to any of its employees.** Coverage will terminate on the date the applicable coverage is no longer offered.
- **You or your dependent obtains coverage under another group plan after your COBRA qualifying event.** Coverage will be terminated effective the first of the month following the date the individual obtained coverage under the other group plan or the date you notify BenefitConnect™ | COBRA, whichever is later. You are obligated to provide notice of the existence of the other coverage, and coverage may be terminated retroactively if notice is provided after the first of the month following the effective date of such other coverage.
- **For any reason the plan would terminate coverage of a non-COBRA participant (such as fraud).**

Premiums or contributions will continue to be accepted and processed until you notify and provide any required documentation to BenefitConnect™ | COBRA. Claims incurred by you or a dependent after the end of the month in which coverage ends will be denied. If claims were paid for expenses incurred after the termination date, you will be required to repay the plan.

For more information

If you need additional information, access https://cobra.ehr.com or call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). Representatives are available from Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time.

For more information about health insurance options available through a Health Insurance Marketplace, visit **healthcare.gov**.

Keep your Plan informed of address changes

To protect your and your family's rights, you should keep BenefitConnect™ | COBRA informed of any changes in your address and the addresses of family members by calling 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at https://cobra.ehr.com. You should also keep a copy for your records of any correspondence with BenefitConnect™ | COBRA.

Plan contact information

For more information about COBRA continuation coverage and the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents), the Wells Fargo & Company Health Care Flexible Spending Account Plan, and the Wells Fargo & Company International Plan:

- Visit https://cobra.ehr.com
- Call the COBRA Administrator, BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only)
- Send a written request to

  BenefitConnect | COBRA
  DEPT: COBRAUS
  PO Box 981914
  El Paso, TX 79998

Notice regarding state continuation of coverage

If you are covered under an insured medical option, you may be entitled to additional continuation of coverage (provided by the insurance carrier in accordance with state law). Contact the insurance carrier that insures your option for more information. If you are not sure whether you are covered under an insured option, you can determine this by looking up your option in this *Benefits Book*.

Notice to individuals covered under a fully insured California health plan

If you are covered by a fully insured California health plan, you may be eligible for an additional 18 months of continued coverage through the insurance carrier insuring your coverage after your federal COBRA continuation coverage ends. This coverage is provided through the California Continuation Benefits Replacement Act (Cal COBRA). Please contact the insurance carrier directly for additional information.

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