WELLS FARGO

A guide to your Wells Fargo benefits

Benefits Book

Effective January 1, 2026

For eligible employees on U.S. payroll

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Information about your plan	For information about medical plans: Included Health 1-833-200-7683 http://www.includedhealth.com/wf or download the Included Health mobile app For all other plans, you may also call 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, or making coverage changes, or plan rates and comparisons	HR Services & Support site Employee Care Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2 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 1-53.

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 N9310-112
550 S. 4th St.
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: Other 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
  - Health Savings Account (HSA) Plan[1,2]
  - Copay Plan with Health Reimbursement Account (HRA)[1]
  - Local Copay Plan with Health Reimbursement Account (HRA)[3]
  - HMO — Kaiser (in certain locations)[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)
- 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
- Wells Fargo & Company Global Business Travel and Accident Plan (Global BT&A)
- Wells Fargo & Company Employee Assistance Program (EAP)

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
  - POS Kaiser Added Choice – Hawaii plan if you live in Hawaii
- Wells Fargo & Company Employee Assistance Program

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 Local Copay Plan with HRA 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 (based on employee data in Workday)" 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*.

Former employees in their severance eligibility period are also eligible to continue participation in or enroll (during Annual Benefits enrollment) in certain benefits as explained in the "Coverage for terminated employees who are receiving Wells Fargo severance pay" section on page 1-51.

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 eligible dependents. When you enroll in one of these benefit plans or corresponding benefit options, you can also enroll 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 enrolled as a dependent may not also be enrolled 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: Some benefit plans do not allow you to enroll 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 beginning 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 enrolled dependent no longer meets applicable eligibility requirements for the plan, you agree to promptly drop your dependent's coverage. Refer to the "You must drop ineligible dependents" section on page 1-49 for more information.

Wells Fargo, the Plan Administrator, the claims administrator, and their delegates or representatives reserve the right to require dependent verification that your enrolled dependents meet applicable eligibility requirements. For more information, see the "Dependent eligibility verification" 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:

	Eligible	Not eligible
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[1] • Your current common-law spouse in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages[1]	• Your spouse who is a Wells Fargo employee and is enrolled in the Wells Fargo-sponsored benefit plan or benefit option as an employee[2] • Your spouse who is enrolled in the Wells Fargo-sponsored benefit plan or benefit option as a dependent of another employee[2] • 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

1. For the Life Insurance Plan, a spouse serving in the military of any country or international authority is not covered during the period of active military duty. If you enroll your spouse in the Life Insurance Plan, a life insurance claim will not be paid if their death occurs while they are on active military duty regardless of the cause of death.
2. 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[1] • 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[1] • Your current same- or opposite-sex domestic partner, if both of you meet all of the following requirements[1]: - 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 current documentation[3] 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[2] • Your domestic partner who is enrolled in the Wells Fargo-sponsored benefit plan or benefit option as a dependent of another employee[2] • 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

1. For the Life Insurance Plan, a domestic partner serving in the military of any country or international authority is not covered during the period of active military duty. If you enroll your domestic partner in the Life Insurance Plan, a life insurance claim will not be paid if their death occurs while they are on active military duty regardless of the cause of death.
2. This does not apply to the Life Insurance Plan or the AD&D Plan.
3. For dependent verification, current documentation is generally within the last six months or in the time frame determined by the plan administrator.

	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[1,2]: - A child who is your or your spouse's or domestic partner's naturally born child[4] - 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[3] • 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 the Life Insurance Plan, a child serving in the military of any country or international authority is not covered during the period of active military duty. If you enroll your child in the Life Insurance Plan, a life insurance claim will not be paid if their death occurs while they are on active military duty regardless of the cause of death.
2. 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: metlife.com/mybenefits.
3. This does not apply to the Life Insurance Plan or the AD&D Plan.
4. For the Life Insurance Plan, a stillborn is not covered under the 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 to be enrolled 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 within 60 days of 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.

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 1-13 for more information.

Incapacitated dependent children

You may also enroll 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 within 60 days of 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 the form is sent 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 1-13 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 1-6, 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, cessation of a domestic partnership, death of domestic partner parent in the case of a domestic partner's child or any other event that results in a loss of eligibility), you must drop your ineligible dependent from coverage. Refer to the "You must drop ineligible dependents" section beginning on page 1-49 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 or failure to provide acceptable proof of dependent eligibility" section on page 1-11.

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."

Dependent eligibility verification

Wells Fargo, the plan administrator, the claims administrator, and their delegates or representatives reserve the right to periodically audit or request verification that your dependents meet applicable eligibility requirements at any time.

You are required to promptly submit proof of eligibility for each of your dependents in connection with enrollment of your dependents in any Wells Fargo-sponsored benefit plan. You also may be required to verify the eligibility for each of your dependents at any time after enrollment. Acceptable forms of proof are stated in the "Proof of dependent eligibility — acceptable documentation" table starting on page 1-10. Additional methods of proof may be added by the plan administrator or its delegate in their discretion.

Your failure to promptly furnish acceptable forms of proof of your dependent's eligibility will result in termination of your dependent's coverage under the plan and consequences of fraudulent enrollment or failure to provide acceptable proof of dependent eligibility may apply. Consequences of fraudulent enrollment or failure to provide acceptable proof of dependent eligibility may also apply if you furnish the requested documentation and it's determined your dependent is not eligible. For more information, see the "Consequences of fraudulent enrollment or failure to provide acceptable proof of dependent eligibility" section on page 1-11.

As part of the dependent verification process, Wells Fargo, the plan administrator, or their delegate (like Alight) may reach out to you for proof of dependent eligibility. After receiving notification with a request for verification, submit acceptable proof of dependent eligibility for each of your dependents whom you have enrolled in any Wells Fargo benefit plan (during your designated enrollment period, during Annual Benefits Enrollment, or during the year as a result of a Qualified Event or special enrollment event) using one of the following submission methods below:

Dependent eligibility verification submission methods

Method	Instructions	Determination timing
Upload **(for fastest results)** using your computer or smartphone	Search for "Dependent Verification" on the HR Services & Support site. From there, log into the Alight system through the link in the article, then click on the "Verify My Dependent Eligibility" alert. You can also access it on Teamworks at Home in the Benefits section. **Note:** Uploaded documents are accepted in the following formats: .jpg, .jpeg, .gif, .bmp, and .pdf. The file size maximum is 7MB per upload.	Expect a determination to be provided to you from Alight within **15-30 days** after Alight's receipt of your request, but you can check the status on Alight's website.
Fax	Fax to 1-866-961-6881.	Expect a determination to be provided to you from Alight within **15-30 days** after Alight's receipt of your request, but you can check the status on Alight's website.
U.S. postal service	The mailing address will be included in your personalized packet from Alight. You can also find it on Alight's website. Any documentation you mail in will not be returned to you.	Expect a determination to be provided to you from Alight within **15-30 days** after Alight's receipt of your request, but you can check the status on Alight's website.
A method provided by the verification administrator at their discretion	If applicable, information will be provided to you by the administrator	Expect a determination to be provided to you from Alight within **15-30 days** after Alight's receipt of your request, but you can check the status on Alight's website.

Proof of dependent eligibility — acceptable documentation

Acceptable documentation to prove your dependent is eligible is noted below. Additional forms of acceptable documentation may be added as determined by the plan administrator or its delegate. **Note:** Any documentation you mail in will not be returned to you.

Dependent relationship	Acceptable proof documentation
Spouse	Two documents are required: one from Section A and one from Section B. <u>Section A</u> • Government-issued marriage certificate,* including date of marriage (no other document from Section B is required if you were married in the past 12 months) • Notarized Affidavit** of Common Law Marriage * Also accepted are spouse's naturalization papers indicating "married" status or immigration papers indicating "married" status in lieu of a marriage certificate. ** Affidavit will be provided on Alight portal and must be signed by both spouses and notarized. This affidavit is only applicable to those states where Common Law Marriage is recognized. **Note:** Wells Fargo notaries may not be used to notarize signatures for this verification process. <u>Section B</u> • Federal or state tax return filed within the last 2 years that lists your spouse (can be married filing separately, but spouse must be listed) • One of the following showing current proof of joint ownership within the last 6 months: - Mortgage statement - Bank statement/bank letter showing account is active - Active lease agreement (can be issued greater than 6 months, if dates show it is currently active, and not month to month) - Any credit card statement - Municipality/county property tax **Note:** On copies of tax forms, bank statements, lease agreements, credit card statements, etc., all financial, account, or Social Security information can be blacked out.

Dependent relationship	Acceptable proof documentation
Domestic partner	Two documents are required: one from Section A and one from Section B. <u>Section A</u> • Notarized Affidavit* of Domestic Partnership • Government-issued Certificate of Civil Union Partnership * Affidavit will be provided on Alight portal and must be signed by both partners and notarized. **Note:** Wells Fargo notaries may not be used to notarize signatures for this verification process. <u>Section B</u> • Proof you and your partner are currently financially inter-dependent, and jointly responsible for each other's basic living expenses. Acceptable proof is any 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 card statement from last 6 months - 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 ** If you and your domestic partner are unable to supply proof that you are financially interdependent, and jointly responsible for each other's basic living expenses, your domestic partner is ineligible under the terms of the Plan.
Biological child	• Government-issued birth certificate that lists the employee's name as parent (international certificates will be recognized with or without translation)
Adopted child or child placed for adoption	• Adoption certificate or adoption placement agreement; or • Government-issued birth certificate that lists the employee's name as the adopted parent, if an amended version was created post-adoption
Stepchild	• Government-issued birth certificate that includes employee's spouse or domestic partner as parent; and • Two documents required to verify the spouse or domestic partner, one from Section A and one from Section B (unless otherwise noted) under "Spouse" or "Domestic Partner" above, as applicable
Legal guardian/ legal custodian	• Government-issued birth certificate; and • Court-ordered document of guardianship
Foster child	• Government-issued birth certificate; and • Foster care Letter of Placement

Consequences of fraudulent enrollment or failure to provide acceptable proof of dependent eligibility

If you fraudulently enroll an ineligible individual, intentionally misrepresent a material fact regarding an ineligible individual, fail to promptly drop coverage for any of your dependents who no longer meet applicable eligibility requirements, fail to submit acceptable proof of dependent eligibility, or your dependent is deemed ineligible based on documentation submitted, 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. **Note:** For newly enrolled dependents, this may be retroactive to the original effective date of coverage.
- 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 National 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 National Medical Support 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 Service Delivery
Benefits Administration
MAC: N9160-014
1801 Park View Dr.
1st Floor
Shoreview, MN 55126-5030

Determining if the order or notice is qualified

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

When Wells Fargo HR Service Delivery 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 1-14 and the "Paying for coverage — interns and flexible employees" section on page 1-15 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.

  You will receive notice 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 beginning on page 1-25.

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: Other 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.

The plan sponsor may determine employee contribution or premium amounts, if any, in its sole discretion. Employee contribution or premium amounts may change every plan year and may also vary based on the following factors:

- **Tobacco-user status.** You designate your tobacco-user status on Workday when you enroll. Tobacco use includes, but is not limited to, cigarettes, electronic cigarettes, cigars, pipes, and chewing tobacco.
  - Your designated tobacco-status on Workday automatically impacts life insurance and medical premiums.
    - Tobacco users are required to pay a tobacco premium surcharge for medical coverage. See the "Cost" section in "Chapter 2: Medical Plans" for more information on the surcharge and the opportunity to have the surcharge waived.
  - Your designated tobacco-status on Workday does not automatically impact your Optional Critical Illness Insurance premiums; however, premiums are differentiated based on the coverage you elect (tobacco-user or non-tobacco user coverage option).
- **Level of coverage.** You elect one of the following levels of coverage if you choose to enroll in medical, dental, vision, optional critical illness, or optional accident insurance coverage:
  - You only
  - You and spouse or domestic partner
  - You and children
  - You and spouse or domestic partner and children
- **Medical premium compensation category.** 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. This includes deducting from your pay any back contributions or premiums for coverage which you may owe (including contributions and premiums retroactive to your date of hire or the date you became eligible for the benefit) to the extent permitted by applicable law.

If you enroll in benefits retroactive to your date of hire or employment classification change (or similar event that allows a retroactive coverage effective date), all benefit premium deductions will be deducted from your first applicable pay period following the date the retroactive enrollment was submitted as long as you have enough in your pay to cover the premium deductions. If you do not have enough in your paycheck, any remaining premium deductions owed will go into arrears and additional contributions, up to the extent permitted by applicable law, will be deducted from your pay until your outstanding past due balance is zero. If you still have an outstanding premium deduction and 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 balance is zero, or at its discretion, the plan administrator (or its delegate) may inform you of additional actions that may be taken by it to address your past due balance.

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 from part-time to full-time or from full-time to part-time, without a change in employee type (for more information on employee type, see the "Who's eligible to enroll" section on page 1-5).
- Becomes effective on the first payroll period after you make benefit election changes when you have a change in employee type (for more information on employee type, see the "Who's eligible to enroll" section on page 1-5).

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, including any retroactive contributions or premium adjustments. 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, additional contributions, up to the extent permitted by applicable law, 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, or at its discretion, the plan administrator (or its delegate) may inform you of additional actions that may be taken by it to address your past due balance. 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 (UnitedHealthcare Global — Expatriate Insurance) (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 page 1-15 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 (UnitedHealthcare Global — Expatriate Insurance) (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 1, 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. This includes deducting from your pay any back contributions and premiums for coverage which you owe (including contributions and premiums retroactive to your date of hire or the date you became eligible for the benefit) to the extent permitted by applicable law.

If you enroll in benefits retroactive to your date of hire or employment classification change (or similar event that allows a retroactive coverage effective date), all benefit premium deductions will be deducted from your first applicable pay period following the date the retroactive enrollment was submitted as long as you have enough in your pay to cover the premium deductions. If you do not have enough in your paycheck, any remaining premium deductions owed will go into arrears and additional contributions, up to the extent permitted by applicable law, will be deducted from your pay until your outstanding past due balance is zero. If you still have an outstanding premium deduction and 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 balance is zero, or at its discretion, the plan administrator (or its delegate) may inform you of additional actions that may be taken by it to address your past due balance.

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 1-53 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" section starting on page 1-17 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 page 1-17 or the "Initial enrollment — interns and flexible employees" section on page 1-17 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 1-21.

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 beginning 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" section on page 1-17. 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" section starting on page 1-17), 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 beginning on page 1-25.

If you are a regular or fixed term employee, you 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 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
- Global Business Travel & Accident (when applicable)
- Employee Assistance Program

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 1-21.

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 beginning on page 1-25.

Initial enrollment — interns and flexible employees

If you currently are, or at some point become, an intern or flexible employee you are automatically enrolled in the Employee Assistance Program, and 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

You must enroll during your designated enrollment period:

- For newly hired or rehired employees, you must enroll within the first 30 calendar days of your hire or rehire date (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 and could result in retroactive premium deduction payments. Also, your claims administrator may not be aware of your enrollment on the date your benefits take effect.

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

Important Arbitration Notice for Kaiser California and Hawaii Employees

If you enroll in a Kaiser California or Hawaii medical plan, you are required to agree to binding arbitration where permitted by ERISA to resolve certain disputes. If you move between the states of California and Hawaii and do not agree to arbitration, you will be defaulted to a national medical plan most like the Kaiser plan you are enrolled. For example, if you are enrolled in a Kaiser HMO, you would default to the Copay Plan with HRA. **Hawaii employees only are eligible for Kaiser; therefore, if you do not agree to arbitration, you will be defaulted to no medical coverage.**

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. If you do not have access to Workday to print a copy of your Benefit Elections, you can request that a paper copy of your Benefit Elections be sent to you at no cost. You may request a paper copy of your Benefit Elections by submitting an HR Request through the HR Services & Support site, or calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

If you notice an error, call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, right away.

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 beginning on page 1-25. For information on paying for coverage, see the "Paying for coverage — regular and fixed term employees" section on page 1-14 or the "Paying for coverage — interns and flexible employees" section on page 1-15, as applicable.

Enrollment and eligibility disputes

Review process for employee enrollment and eligibility disputes

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. **Note:** This section does not address dependent verification disputes. For information on that process, see the "Review process for dependent eligibility verification disputes" section starting on this page.

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 N9310-112
550 S. 4th St.
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 is 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: Other Notifications and Disclosures."

Review process for dependent eligibility verification disputes

Any determination to terminate your dependent's enrollment in Wells Fargo-sponsored benefit plans ("the plans") in response to the dependent eligibility verification request is based on the information you provided (or failed to provide) to Alight and applicable Wells Fargo plan provisions. Any person identified as "Not verified" during the verification process is not eligible to be enrolled in the plans and will have coverage terminated as of the date the verification process has concluded and the

dependent has been determined to be ineligible (the "determination date").

If you do not agree with the Alight determination about your dependent's eligibility, you can request a review disputing the determination within 30 days immediately following the end of your 60 day level one review period with Alight.

First level dependent eligibility verification dispute review request

Submit the required information to the Dependent Verification Dispute Management team at Alight using one of the methods described in the "Dependent eligibility verification submission methods" table on page 1-10. Mailing information will be included in your personalized packet from Alight along with a personalized coversheet to be utilized when faxing or mailing documentation. Any documentation submitted must include your unique account ID to ensure proper and expedient processing. Do not share the personalized information with others.

Required information for your dispute submission:

- Personalized coversheet received in the packet of information from Alight
- A letter explaining why you are disputing the determination
- Acceptable documentation to prove your dependent is eligible is listed in the "Dependent eligibility verification" section on page 1-9

Second level dependent eligibility verification dispute review request

If Alight determines that your dependent is ineligible in response to receiving and reviewing your first level review request, you have the right to have Wells Fargo review your documentation. For this second level of review, submit your written dispute along with any additional documentation that you believe supports your dependent's eligibility no later than 30 days after you received the Alight first level appeal review determination by uploading the information to the Alight portal online, or by secure fax 1-866-961-6881, or by U.S. mail to the following address:

Alight
Dependent Verification Center
PO Box 299108
Lewisville, TX 75029-9108

Wells Fargo Corporate Benefits will make a determination within 30 days of receipt of your request. A written determination will be mailed to your home address.

Determination authority

Wells Fargo Corporate Benefits, on behalf of the plan administrator, has complete discretionary authority to make decisions relating to eligibility for initial or continued enrollment in the respective plans, subject to the terms of the applicable plan documents and governing federal law. Inquiries about eligibility and enrollment, or termination of coverage that are within the plan administrator's authority, are generally not subject to statutory claims and appeals procedures. Corporate Benefits has delegated responsibility for eligibility reviews for dependent verification to Alight, pursuant to the process described above. The determination of Corporate Benefits or its delegate is conclusive and binding on all parties and is 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: Other Notifications and Disclosures."

Review process for tobacco surcharge disputes

If you are designated as a tobacco user on Workday and you are enrolled in an applicable Wells Fargo & Company medical plan, you will be charged a per pay period tobacco surcharge in addition to your medical premium deduction.

If you have enrolled in the Quit for Life® tobacco cessation program through Optum Rally and it's been more than 30 days and you have still have not received the tobacco surcharge credit on your paycheck, follow the steps below:

- Call Quit for Life® at 1-866-784-8454 to confirm the enrollment date (you will need this for further research).
- After you have confirmed the enrollment date with Quit for Life® and if more than 30 days has passed since enrollment, contact Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2 with your date of enrollment for further review and determination.

Note: Dispute requests made before 30 days from your enrollment date in Quit for Life® will not be reviewed.

If you are dissatisfied with a determination, you may submit a written request for a review of the determination to Corporate Benefits, on behalf of the plan administrator, at the following address:

Corporate Benefits
Wells Fargo & Company
MAC N9310-112
550 S. 4th St.
Minneapolis, MN 55415

Corporate Benefits cannot accept requests sent by fax or email. Before you send a request to Corporate Benefits for review, you must have completed the Employee Care review and determination process. Corporate Benefits must receive your written request for review within 120 days from the date you enrolled in the Quit for Life® tobacco cessation program. Any requests received after 120 days will not be reviewed.

Corporate Benefits, on behalf of the plan administrator, has sole and complete discretionary authority to make decisions relating to application of the tobacco surcharge in the respective plans, subject to the terms of applicable plan documents and governing federal law. Inquiries related to tobacco surcharge application are within the plan administrator's authority and 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 is not subject to further review. Before taking any legal action

with respect to a tobacco surcharge 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: Other Notifications and Disclosures."

Payment adjustments for benefit coverage

If the enrollment and eligibility 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 1-13.
- 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

New employees (including international transfers)

The following are part of the total benefits package for eligible regular or fixed term employees and effective on your date of hire — you're automatically enrolled, at no cost to you:

- Basic Term Life
- Business Travel Accident
- Basic Critical Illness[1]
- Short-Term Disability
- Basic Long-Term Disability
- Global BT&A, as applicable
- Employee Assistance Program[2]

If you enroll in benefits during your designated enrollment period as described in the "How to enroll" section starting on page 1-16, the following benefits are effective on your date of hire:

- Medical[1]
- Dental[1]
- Vision[1]
- Health Care FSA
- Day Care FSA
- Optional Term Life Insurance
- Spouse/Partner Optional Term Life Insurance
- Dependent Term Life Insurance
- Accidental Death & Dismemberment
- Optional Long-Term Disability
- Legal Services
- Optional Critical Illness[1]
- Optional Accident Insurance[1]

1. The medical, dental, vision, critical illness, and optional accident insurance benefit options have no preexisting condition exclusions.
2. Employee Assistance Program also applies to flexible employees and interns

Note: For eligible dependents enrolled during your initial designated enrollment period, their coverage begins when your coverage begins.

Your coverage effective date may vary in the following situations:

- 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 STD, Basic LTD, Optional LTD, Basic Term Life, Optional Term Life, Spouse/Partner Optional Term Life, Dependent Term Life, Basic Critical Illness Insurance, Optional 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). See the applicable chapter for more information.
- Spouse/Partner Optional Term Life coverage, Dependent Term Life coverage, and dependents enrolled in Optional Critical Illness Insurance and Optional Accident Insurance coverage are subject to the nonconfinement clause as described in the "Delayed effective date" section of the applicable chapter.
- Amounts above guarantee issue for Optional Term Life and Spouse/Partner Optional Term Life are subject to Statement of Health approval by MetLife, as described in the "Statement of health" section of "Chapter 7: Life Insurance Plan".
- 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 for medical, dental, vision, life insurance, legal services, and short- and long-term disability coverage the date you become a localized U.S.-based employee. All other benefits become effective the first of the month following the date you become a localized U.S.-based employee. 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, Spouse/Partner Optional Term Life, Dependent Term Life, Critical Illness Insurance, and Accident Insurance coverage will be 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, medical coverage under the U.S. benefits as an intern or flexible employee becomes effective the date you become a localized U.S.-based employee.

- The effective date of coverage under the Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance) 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 were covered under the Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance) 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 following the date your international assignment ended.
- For the effective date of COBRA continuation coverage, refer to "Appendix E: Continuing Coverage Under COBRA."

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 within 30 days of your termination date, your benefits, described in this benefits book, that were in effect prior to your termination date will be reinstated effective on your date of rehire. Coverage and premium amounts may differ as covered pay and medical eligible premium compensation is based on salary and payroll information as of date of rehire. You can make changes during the next Annual Benefits Enrollment or after a qualified event.

If you were previously employed by Wells Fargo & Company or any of its subsidiaries or affiliates, your employment was terminated, and you are rehired more than 30 days after your Wells Fargo termination date, your benefits enrollment and coverage effective date are handled like a new employee. See the "New employees (including international transfers)" section on page 1-20. However, there are certain important exceptions for those individuals who are rehired with a first day of reemployment during their severance eligibility period, as stated in the "Rehire while on severance" table on page 1-22. In addition, reinstatement of Optional Long-Term Disability coverage depends on the length of time between your termination and rehire dates; see "Chapter 12: Long-Term Disability Plan" for more information.

Rehire while on severance

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

• Your coverage in the following company-paid benefit options continues on your first day of reemployment: - Basic Term Life* - Business Travel Accident (BTA)* - Basic Critical Illness Insurance - Short-Term Disability* - Short-Term Disability Top-Up Plan*, as applicable - Employee Assistance Program	• Coverage (benefit plan option and coverage level) in effect on the day before your rehire date continues on your first day of reemployment for the following benefits; 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 - Optional Term Life* - Spouse/Partner Optional Term Life - Dependent Term Life - Accidental Death and Dismemberment (AD&D) Plan - Legal Services Plan - Optional Critical Illness Insurance - Optional Accident Insurance **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 those benefits as a rehired employee. You may enroll in coverage only when 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 1-25. You may also request late enrollment for the life insurance options at any time, see "Chapter 7: Life Insurance Plan" for more information.	• Coverage is effective on your date of rehire if you make a new election for the following benefits within the first 30 calendar days, starting on your rehire date: - Day Care Flexible Spending Account

* The dollar value may differ depending on the covered pay associated with your job as a rehired employee.

Note: 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, Spouse/Partner Optional Term Life, Dependent Term Life, Critical Illness Insurance (basic and optional), and Accident Insurance coverage is delayed until you return to work.

Rehired retirees

Generally, if you are rehired within 30 days of your Wells Fargo termination date, the benefits, described in this benefits book, that were in effect prior to your termination will be reinstated on your rehire date. Coverage and premium amounts may differ as covered pay and medical eligible premium compensation is based on salary and payroll information as of date of rehire. You can make changes during the next Annual Benefits Enrollment or after a qualified event. Otherwise, your benefits coverage as an employee in a regular or fixed term position begins the same as any other new employee.

However, 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 rehire 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") 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*.

Note: 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.

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 day of your employment classification change. 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:

- Your medical, dental, vision, Health Care FSA, Day Care FSA, life insurance, BTA, AD&D, disability (STD and LTD), Legal Services, Critical Illness Insurance, and Optional Accident Insurance coverage begins on the date you become a regular or fixed term employee.
- For eligible dependents enrolled during your initial designated enrollment period, their coverage begins when your coverage begins.

Note: 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.

Enrollment election changes

See the "Changing coverage" section beginning on page 1-25.

COBRA continuation coverage

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

Coordination with other coverage

General coordination of benefits

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 may be able to change your benefit elections for certain benefit plans and options within 60 days of the date of a Qualified Event or a special enrollment event (the 60 days includes the day of the event) 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 beginning on page 1-29 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 beginning on page 1-28 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 beginning 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. You can also decrease AD&D coverage during the year for any reason. 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" section starting on page 1-26 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.)

See the "How to change your benefit elections" section starting on this page for information on how to make benefit changes.

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

How to change your benefit elections

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" and then click on "Submit," the enrollment will be forwarded to HR for approval, if required.

To drop AD&D coverage, Optional Critical Illness Insurance coverage, or Optional Accident Insurance coverage, decrease your AD&D coverage level, or to drop an ineligible dependent

from Optional Critical Illness Insurance coverage or Optional Accident Insurance coverage during the year, call Employee Care at 1-877-HRWELLS (1-877-479-3557). option 2.

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 "Changing coverage" section starting on page 1-25 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 1-33.

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 "Chapter 7: Life Insurance Plan" 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 are a terminated employee who is receiving severance benefits, any new or increased insurance coverage elections will not become effective in January, and you will retain your current coverage.

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 (UnitedHealthcare Global — Expatriate Insurance); see the "Additional requirements for the Wells Fargo & Company International Plan, (UnitedHealthcare Global — Expatriate Insurance)" section on page 1-6 for more information.
- 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 from the date of the move (the date you moved is included in the 60 days) 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 (the date you moved is included in the 60 days) 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. 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 (UnitedHealthcare Global — Expatriate Insurance); see the "Additional requirements for the Wells Fargo & Company International Plan, (UnitedHealthcare Global — Expatriate Insurance)" section on page 1-6 for more information.

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 (UnitedHealthcare Global — Expatriate Insurance), 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 beginning 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 contacting 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 beginning on page 1-25 for more information.

You may also make your enrollment election 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 by contacting Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

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 1-31 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 1-31. 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 beginning on page 1-25 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 beginning 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 1-31.

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" section on page 1-17.
- 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 or failure to provide acceptable proof of dependent eligibility" section on page 1-11.

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 (or deceased) spouse or former domestic partner. **You must drop any dependent of your former (or deceased) spouse or domestic partner unless either:** (1) the child also qualifies as your dependent (i.e. naturally born or legally adopted child, child placed with you for adoption or for whom you are a legal guardian), or (2) a court or other appropriate government entity issues a Qualified Medical Child Support Order (QMSCO) that requires you to maintain coverage. **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 1-43 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 or domestic partner'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 beginning on page 1-27* ***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 1-43 of this Qualified Events table.
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	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.

You must drop 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, your child turns age 26, or any other event that results in a loss of eligibility), you must drop coverage by submitting the change 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 beginning 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 or failure to provide acceptable proof of dependent eligibility" section on page 1-11.

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 beginning on page 1-25).

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 beginning on page 1-26 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 beginning on page 1-26 and the "Qualified Events" section beginning on page 1-29 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, and make elections to participate during Annual Benefits Enrollment, in the following Wells Fargo-sponsored voluntary benefit options as long as you pay or 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]
- Legal Services

You will be able to continue participating in the following plans; however, you will not be able to enroll or increase coverage in the following plans while you are receiving severance benefits, including during Annual Benefits Enrollment:

- Life Insurance (Basic Term Life[3], Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverages)
- Accidental Death and Dismemberment
- 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 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: Other Notifications and Disclosures."

If you elected coverage under the Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance); your medical coverage under the 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 or failure to provide acceptable proof of dependent eligibility" section on page 1-11.

Summary Plan Descriptions for each benefit plan

Benefit plan name	Benefit option	SPD components
Wells Fargo & Company Health Plan	HSA Plan (including HSA Plan 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: Other Notifications and Disclosures" • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
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: Other Notifications and Disclosures" • "Appendix D: Leaves of Absence and Your Benefits" • "Appendix E: Continuing Coverage Under COBRA"
Wells Fargo & Company Health Plan	Local Copay Plan with HRA (self-insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Chapter 2: Medical Plans" • "Appendix A: Claims and Appeals" • "Appendix B: Other 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: Other Notifications and Disclosures" • Kaiser Evidence of Coverage (provided by Kaiser; visit https://choose.kaiserpermanente.org/wells-fargo • "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	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: Other Notifications and Disclosures" • Kaiser Evidence of Coverage (provided by Kaiser; visit https://choose.kaiserpermanente.org/wells-fargo • "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: Other 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: Other 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)	UnitedHealthcare Global — Expatriate Insurance[1] (insured)	• "Chapter 1: Eligibility, Enrollment, and More" • "Appendix B: Other 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: Other 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," "Future of the plans" sections, and applicable portions of the "ERISA plans sponsored by Wells Fargo" table 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: Other 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: Other 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: Other 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: Other 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: Other 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: Other 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: Other Notifications and Disclosures"[1, 2] • "Appendix D: Leaves of Absence and Your Benefits"
Wells Fargo & Company Global Business Travel and Accident Plan	Global Business Travel and Accident Plan (insured)	• Chapter 16: Global Business Travel & Accident Plan

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," "Future of the plans" sections, and applicable portions of the "ERISA plans sponsored by Wells Fargo" table apply.

Benefit plan name	Benefit option	SPD components
Wells Fargo & Company Employee Assistance Program	Employee Assistance Program (self-insured)	• Chapter 17: Employee Assistance Program
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: Other 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: Other 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 13: Legal Services Plan" • "Appendix B: Other 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," "Future of the plans" sections, and applicable portions of the "ERISA plans sponsored by Wells Fargo" table apply.

Chapter 2: Medical Plans

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Contacts

Call Included Health for general information about: • Medical plans • In-network providers • Telemedicine/virtual visits • Claims-related questions	1-833-200-7683 includedhealth.com/wf Mobile app*: Included Health
Information about the medical plans administered by UnitedHealthcare (UHC)	1-800-842-9722 myuhc.com https://www.liveandworkwell.com (access code: wellsfargo) for mental health and substance use services Mobile app*: UnitedHealthcare (United Healthcare Services, Inc.)
Information about the medical plans administered by Anthem Blue Cross and Blue Shield (Anthem BCBS)	1-866-418-7749 anthem.com Mobile app*: Sydney Health (Anthem Insurance Companies, Inc.)
Information about the medical plans administered by Centivo	1-877-320-4577 centivo.com/wf Mobile app*: Centivo app
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	For all Kaiser plans, visit https://choose.kaiserpermanente.org/wells-fargo You may also call the applicable Kaiser number below or use the Mobile app*: Kaiser Permanente (Kaiser Permanente). Kaiser California (Northern and Southern) 1-800-464-4000 Kaiser Colorado 1-800-632-9700 Kaiser Hawaii 1-800-966-5955 Kaiser Mid-Atlantic 1-800-777-7902 – All areas Kaiser Northwest (Oregon and SW Washington) 1-800-813-2000 Kaiser Washington 1-206-630-4636 – Seattle area 1-888-901-4636 – All other areas 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 site 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
HSA Plan* Flex HDHP * Including Out of Area, where applicable	Anthem Blue Cross and Blue Shield	Alabama, Alaska, California (Northern and Southern), Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming
	UnitedHealthcare	Arizona, Arkansas, Colorado, District of Columbia, Florida, Iowa, Kansas, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, Oklahoma, Tennessee, Utah, Wisconsin
Copay Plan with HRA	UnitedHealthcare	All states except Hawaii
Local Copay Plan with HRA	Anthem Blue Cross and Blue Shield	Florida, Georgia (Atlanta-Sandy Springs-Roswell, Augusta, Columbus, and Savannah), Missouri (St Louis Metro Area), North Carolina (Charlotte, Concord-Gastonia Metro Area)
	Centivo	Connecticut, Iowa (Des Moines and certain other Iowa locations), New Jersey, New York, Pennsylvania
	UnitedHealthcare	Arizona (Phoenix area), Illinois (Chicago area), Minnesota (Minneapolis/St. Paul Metro area), Texas
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 (Northern and Southern), Colorado, 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 Local Copay Plan with HRA and Kaiser medical plans is limited to regular and fixed term employees whose permanent residential (home) address is within the applicable service area
- Flexible employees and interns are only eligible for the Flex HDHP (or only the POS Kaiser Added Choice if your permanent home address is in Hawaii).
- 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 Wells Fargo & Company 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 (UnitedHealthcare Global — Expatriate Insurance); see the "Additional requirements for the Wells Fargo & Company International Plan, (UnitedHealthcare Global — Expatriate Insurance)" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix A: Claims and Appeals," "Appendix B: Other 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

The SPD provides a summary of the provisions for the self-insured medical options under the Health Plan and some of the provisions for the insured medical options. See the "Insured medical plan options" on page 2-8 and the "Self-insured medical plan options" on page 2-9 for more information.

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

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 reviews, 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.

Claims administrator

The claims administrator for the medical plan you enroll in depends on the state you live in and the medical plan you elect. See the "Medical plans by location" starting on page 2-5 to determine the claims administrator.

Medical plans highlights

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

Generally, the medical plans provide coverage for eligible:

- Office visits
- Telemedicine visits through Included Health
- Urgent Care
- Preventive exams and immunizations
- Diagnostic procedures
- Treatment for illnesses and injuries
- Maternity and fertility services
- Emergency care for life-threatening conditions
- Wellness opportunities

The detailed benefits and coverage information is described in this chapter or in other materials sent to you by the insurer. You must be enrolled in a medical plan on the date of service to receive applicable benefits under that medical plan.

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 or other medical provider 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

See the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment as a new hire, rehire, or if you have an employment classification change and become eligible to enroll in benefits. 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

If you did not enroll when first eligible or you want to make changes to your enrollment election, you may do so 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."

You must drop your dependent from coverage in Workday when they are no longer eligible. See the "You must drop ineligible dependents" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

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 following:

- The medical plan you elect
- Your level of coverage under that medical plan
  - You only
  - You + spouse*
  - You + children
  - You + spouse* + children

* The term "spouse" includes your domestic partner

- Your tobacco-user status
  - Tobacco use includes, but is not limited to, cigarettes, electronic cigarettes, cigars, pipes, and chewing tobacco.
  - Employees who enroll in the medical plan options and who have identified themselves as tobacco users on Workday must pay a premium surcharge of $600 annually (applied pro rata as premium amounts are charged) for Wells Fargo medical plan coverage. To qualify for a credit of the entire tobacco surcharge for the current plan year, impacted employees had to enroll in the Quit For Life® tobacco cessation program by December 14 of the previous plan year as described in your annual enrollment materials. If an impacted employee enrolls in Quit For Life® after December 14 of the previous plan year, any tobacco surcharge credit will apply prospectively against future premium contributions in the new plan year, if applicable.
  - For example, if you enrolled in the Quit For Life® tobacco cessation program by December 14, you will qualify for a credit of the entire tobacco surcharge for the current year. But if you enrolled in the Quit For Life® tobacco cessation program after December 14, the tobacco surcharge credit will be applied to the premium contribution on the first administratively feasible payroll period in the following year.
  - For more information on Quit For Life®, see, the "Quit For Life®" section on page 2-36. This program is voluntary and offered as part of the wellness program. An accommodation process is also available, as described in the "Requests for accommodations" section on page 2-36. **Note:** The surcharge does not apply to the Flex HDHP or the Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance). The surcharge also does not apply to COBRA participants enrolled in any 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 in the "Medical premium compensation category" section starting on this page.

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

Medical premium compensation category:

- Eligible compensation of less than $48,000
- Eligible compensation of $48,000 to $100,000
- Eligible compensation of more than $100,000 to $250,000
- Eligible compensation of more than $250,000 to $500,000
- Eligible compensation of more than $500,000

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. Access Workday to determine your job class code (select Job Profile in Job Details section, page down to the Job Classifications section and click +More).

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 — job class 2

    Eligible compensation is based on your annual base salary[2] (for hourly employees, your standard hours[4] multiplied by your hourly wage multiplied 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 — job class 5 and 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 "For Annual Benefits Enrollment elections" bullet above.

- 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 —job class 2

    Eligible compensation is determined based on your annual base salary[2] (for hourly employees, 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 —job class 5 and 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.

Medical plan options

Insured medical plan options

Noted below are the fully insured medical plans under the Wells Fargo & Company Health Plan ("Health Plan") available to employees in certain locations (see the "Medical plans by location" section on page 2-5 to see if HMO — Kaiser is available in your area):

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

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 HSA Plan, Copay Plan with HRA, Local Copay Plan with HRA, 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.

Important Arbitration Notice for Kaiser California and Hawaii Employees

To enroll in a Kaiser California or Hawaii medical plan, you are required to agree to binding arbitration where permitted by ERISA to resolve certain disputes. If you move between the states of California and Hawaii and do not agree to arbitration, you will be defaulted to a national medical plan most like the Kaiser plan you are enrolled. For example, if you are enrolled in a Kaiser HMO, you would default to the Copay Plan with HRA. **Hawaii employees only are eligible for Kaiser; therefore, if you do not agree to arbitration, you will be defaulted to no medical coverage.**

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 the Kaiser insured medical plan options. Separate documentation is provided directly from or made available to you by Kaiser if you enroll in the applicable plan (see the "Contacts" section on page 2-4 to obtain more information from Kaiser).

Information noted in the following sections of this chapter:

- The "Who's eligible" section on page 2-6
- The "How to enroll and when coverage begins" section on page 2-6
- The "Changing or canceling coverage" section on page 2-7
- The "When coverage ends" section on page 2-7
- The "Cost" section on page 2-7
- The "Medical plan options" section on page 2-8, excluding the "Self-insured medical plan options" subsection
- The "Health and wellness activities" section starting on page 2-31, 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 ("Health Plan"):

- For regular and fixed term employees:
  - HSA Plan*
  - Copay Plan with Health Reimbursement Arrangement (HRA)*
  - Local Copay Plan with HRA available to employees in certain locations (see the "Medical plans by location" section on page 2-5 to see if this plan is available in your area)

* Including Out of Area coverage. Unless otherwise indicated, references in this chapter to the HSA Plan and Copay Plan with HRA include the applicable Out of Area coverage.

- For interns and flexible employees:
  - Flexible High Deductible Health Plan (Flex HDHP)

Note: The health savings account that you open in conjunction with your enrollment in the HSA Plan 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 HSA Plan and Flex HDHP work" section starting on page 2-26
- "How the Copay Plan with HRA and Local Copay Plan with HRA work" section starting on page 2-15
- "Health and wellness activities" section starting on page 2-31

Claims administrator

The HSA Plan, Copay Plan with HRA, Local Copay Plan with HRA, 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 "Who's eligible" section on page 2-6
  - The "How to enroll and when coverage begins" section on page 2-6
  - The "Changing or canceling coverage" section on page 2-7
  - The "When coverage ends" section on page 2-7
  - The "Cost" section on page 2-7
  - The "Medical plan options" section on page 2-8, 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"

Included Health

Included Health provides a single place to help you find clinical, financial, or administrative information for your medical plan. It also provides on-demand telemedicine for physical and mental health needs.

Navigation and member support

Care coordinators are available by phone or chat, 24 hours a day, seven days a week, to help you with:

- A Benefits Directory to view and connect you with your benefits
- A Get Care page to help you find providers, including telemedicine providers
- Benefits routing to get recommendations for relevant benefits
- Provider details (for example, how to identify an in-network provider with Anthem BCBS, Centivo, or UnitedHealthcare)
- Your claims activity
- HSA/HRA balance information
- Your deductible and out-of-pocket information
- Live support available via phone or chat

Expert Medical Opinion — second medical opinion

Included Health can provide a second medical opinion from an independent medical provider on a diagnosis or treatment plan provided or recommended by another provider, to help you understand your options and make informed choices about your care.

Telemedicine

Included Health provides medical and behavioral virtual visits. Medical virtual visits offer an integrated, on-demand visit with an urgent care medical staff. Behavioral virtual visits offer highly accessible therapy and psychiatry clinicians for behavioral health needs. For what you will pay for telemedicine visits, see the "Cost-sharing for telemedicine visits with Included Health" section on page 2-49.

How to contact Included Health

For information about any of the services provided by Included Health, or to talk with a member care advocate, visit www.includedhealth.com/wf or call 1-833-200-7683. You can also download the Included Health app to your mobile device.

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 but not limited to your 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 — general information

Provider networks consist of participating licensed medical professional providers and facilities that have entered into an agreement with your claims administrator to provide health care services to covered members at negotiated rates. These providers are referred to as in-network providers. You can verify the network status of your provider by contacting:

- Included Health; see the "Contacts" section on page 2-4
- Your claims administrator by calling the number on the back of your card or see the "Contacts" section on page 2-4

Enrollment in a medical plan does not guarantee the availability of any particular physician or provider 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 more information see the "When your provider leaves the network" section on page 2-11.

For the HSA Plan and the Copay Plan with HRA, you have the choice to see any provider for most covered health services, and no referrals are required to see a specialist. But you will generally pay less for eligible covered health services when you receive services from an in-network provider.

- For the HSA Plan, it is recommended that you have a primary care physician (PCP) whom you see regularly who is familiar with your health needs.
- For the Copay Plan with HRA, you will be asked by UnitedHealthcare to designate a Tier 1 primary care

physician (PCP) whom you see who is familiar with your health needs. If you do not designate a primary care physician (PCP), one will be designated for you. While a designated PCP is required, PCP referrals are not required to access other Tier 1 or Tier 2 PCPs or specialists.

When you travel and need to see a provider in another state, or if you have dependents living out of state, you may have access to in-network providers throughout the U.S. Contact Included Health or your claims administrator for information about the availability of in-network providers in a specific area. Also, see the specific information in claims administrator sections that follow for more information.

If you are enrolled in the HSA Plan or Copay Plan with HRA 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 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 at the in-network level regardless of whether you receive services from an in-network or out-of-network provider and you are not required to designate a PCP. **Note:** 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.

For the Local Copay Plan with HRA, you are required to go to an in-network provider associated with the specific local network, as determined by the claims administrator, for your plan and geographic area. Contact Included Health or your claims administrator to identify network providers in your area. **Note:** There is no out-of-network coverage (except for emergencies) and no Out of Area coverage available under the Local Copay Plan with HRA, even if you are traveling or have dependents living out of state, unless authorized by your claims administrator.

Also, depending on the local network in your area, 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 or another provider. For more information, see the specific information in claims administrator sections that follow.

When your provider leaves the network

Because a provider's participation with your claims administrator's network can change at any time, you should confirm with your provider before each service that the provider is participating in your claims administrator's network.

If your provider or facility is leaving or has left the plan's network due to nonrenewal or expiration of their contract, the claims administrator will notify you.

- You will need to notify the claims administrator if you require continuing transitional care with that provider or facility for a serious or complex condition, pregnancy, terminal illness, scheduled non-elective surgical care, or if you are undergoing inpatient or institutional care. You may have a right to elect to continue transitional treatment and still be covered by the plan under the same terms and conditions that existed when the provider or facility was part of the plan's network. Such coverage would be temporary, up to a maximum of 90 days. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, call your claims administrator at the telephone number on your ID card.
- If you receive covered services from an out-of-network provider and were informed by the claims administrator (either through a request by phone or through the provider database) prior to receiving the covered services that the provider was in-network, you may be eligible for cost-sharing that would be no greater than if the covered services were through an in-network provider.

UnitedHealthcare provider networks

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

HSA Plan – UHC and Flex HDHP – UHC

The UnitedHealthcare Choice Plus Network is the network of providers associated with the HSA Plan and the Flex HDHP administered by UnitedHealthcare. You can see any UnitedHealthcare Choice Plus Network provider nationwide and receive in-network benefits for eligible covered health services. You can identify Choice Plus Network providers at includedhealth.com/wf or at myuhc.com.

Copay Plan with HRA

This plan has two tiers of in-network providers. You will generally pay less for eligible covered health services if you use a Tier 1 in-network provider.

- **Tier 1:** The UnitedHealthcare high-performance Nexus ACO network is the Tier 1 network. If you see a Tier 1 in-network provider, you pay Tier 1 copays, deductibles, and co-insurance for eligible covered health services. The Tier 1 annual out-of-pocket maximums also apply.
- **Tier 2:** The UnitedHealthcare Choice Plus Network is the Tier 2 network. If you see a Tier 2 in-network provider, generally, you pay Tier 2 copays, deductibles, and co-insurance for eligible covered health services. The Tier 2 annual out-of-pocket maximums also apply.

For certain eligible covered health services, the Tier 1 copays, deductibles, coinsurance, and annual out-of-pocket maximums apply regardless of whether you see a Tier 1 or Tier 2 in-network provider. To determine if that applies to services you need, see the individual covered services sections in this chapter.

If you have Copay Plan with HRA Out of Area coverage you will pay Tier 1 copays, deductibles, and coinsurance for eligible covered health services. The Tier 1 annual out-of-pocket maximums also apply.

Local Copay Plan with HRA – UHC

You must see a provider that is part of your specified local area network:

- **In Arizona (Phoenix area)**, the Banner Health network is the local area network of providers for the Local Copay Plan with HRA administered by UnitedHealthcare. You are not required to designate a primary care care physician (PCP) at enrollment, but it's recommended that you establish a medical care relationship with a Banner Health PCP who is familiar with your health needs.
- **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 for the Local Copay Plan with HRA administered by UnitedHealthcare. 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) and Texas**, the UnitedHealthcare Charter Network ("Charter Network") is the local network of providers associated with the Local Copay Plan with HRA administered by UnitedHealthcare. After UnitedHealthcare is notified of your enrollment, they will reach out to you to tell you how to designate a Charter Network primary care physician (PCP), which is required. If you have questions about designating a PCP, contact UnitedHealthcare at 1-800-842-9722.

  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 use provider, nurse practitioner, physician assistant, or optometrist within your local area network.

  Changing your Charter Network PCP (post enrollment)

  - You may request PCP changes by calling Customer Service at the toll-free number on your 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.
  - After you change your PCP, a new member card will be generated. You should receive it within seven to 10 days. You can view the image of the new card reflecting the new PCP within 48 to 72 hours on myuhc.com.
- **If your home location is Arizona, Minnesota, Illinois, or Texas and 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 2-66 for more information).
  - **Nonemergency care**
    If you or a covered family member are outside your local network service area and need nonemergency 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.

HSA Plan – Anthem and Flex HDHP – Anthem

If your primary home address is in:

- Georgia: your provider network is Blue Open Access POS (Select Network)
- New Hampshire: your provider network is BlueChoice Open Access POS (Select Network)
- Virginia, except for northern Virginia: your provider network is HealthKeepers POS (Select Network). For Northern Virginia: your provider network is Blue Choice Advantage
- New Jersey: your provider network is Horizon Managed Care
- Other locations within the United States: your provider network is National BlueCard PPO (BlueCard PPO)

In addition, employees at certain locations have access to clinics in or near their assigned work location. This includes the The Health Center at Hudson Yards for employees whose work location is in the 30 Hudson Yards building in New York City, New York. 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 in-network providers at includedhealth.com/wf or at anthem.com.

Local Copay Plan with HRA – Anthem

You must see a provider in Anthem BCBS's Blue High Performance Network (Blue HPN) for your local area:

- Florida
- Georgia (Atlanta-Sandy Springs-Roswell, Augusta, Columbus, and Savannah)
- Missouri (St Louis Metro Area)
- North Carolina (Charlotte, Concord-Gastonia Metro Area)

You can identify Blue HPN local network providers at includedhealth.com/wf or at anthem.com. 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.

If you need services outside your local home Blue HPN 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" section starting on page 2-66 for more information).
- **Nonemergency care**
  If you need nonemergency services while traveling, contact Anthem at 1-866-418-7749 before receiving services; they may be able to assist you in finding care from an in-network provider. Depending on where you travel within the U.S., you may have access to in-network providers within the BlueHPN. You will not receive benefits for services from a provider not in the BlueHPN.

Centivo provider network

Local Copay Plan with HRA – Centivo

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

You must see a provider in the Centivo network for your local service area:

- Iowa (Des Moines area)
- Connecticut
- New Jersey
- New York
- Pennsylvania

You can identify your local area Centivo in-network providers at includedhealth.com/wf or at centivo.com/wf. You are required to have a designated primary care physician (PCP) who coordinates your care. You must select a PCP by visiting Centivo at centivo.com/wf or by contacting Centivo by phone. You may also have Centivo elect a PCP for you. You can change your PCP at any time. **Note:** If you do not have a designated PCP, coverage will be limited to emergency services and services for which you do not need a referral (see the "Referrals" section on this page).

If you need services when outside your local Centivo 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" section on page 2-66 for more information).
- **Nonemergency care**
  If you or a covered family member are outside your Centivo network service area and need nonemergency medical services, generally, **you will not receive benefits for services received from an out-of-network provider** unless authorized by Centivo, or as provided under the plan. If you travel outside of your home network area, please contact Centivo at the number on your ID card for more information. Centivo may be able to assist you with locating participating providers.

Referrals

Under the Local Copay Plan with HRA administered by Centivo, your PCP should be your first point of contact for all your care needs. **If you need specialist care or services from a provider who is not your PCP (or part of your PCP care team) you are required to first get a referral from your designated PCP**, with some exceptions noted below.

- Your PCP will submit the referral to Centivo on your behalf, but it is your responsibility to ensure your PCP submitted the referral before you receive additional care.
  - You will get a message in the Centivo App and/or member portal after your PCP submits a referral.
- After the referral is submitted, you should try to schedule an appointment with the doctor you were referred to.
  - If they're unavailable, you can schedule an appointment with another doctor of the same specialty at the same practice without a new referral.
  - If you need to schedule an appointment with a doctor at a different practice, you will need a new referral from your PCP.
- If a service requires a referral and you do not get one from your PCP, you will pay an additional $25 in addition to any copay for office visits for in-network services.
- If you do not have a referral for an in-network surgeon performing a nonemergency procedure, you will pay an additional $250 for out-patient surgical services, and an additional $500 for inpatient services in addition to other cost-sharing requirements (deductible and coinsurance).

The following services received from other Centivo in-network providers do not require a referral from your PCP:

- Urgent care
- Emergency medical care (including out-of-network providers)
- OB/GYN care
- Behavioral health/substance use disorder care
- Physical therapy
- Occupational therapy

- Speech therapy
- Chiropractic care
- Alternative medicine care (e.g., acupuncture)
- Lab work
- X-rays (**Note:** you are still required to receive a referral for CT scans, PET scans, and MRIs)
- Other covered tests and services for which applicable laws and regulations do not allow Centivo to impose a referral requirement.
- Included Health telemedicine/virtual visits

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. However, for the Copay Plan with HRA, the Tier 1 and Tier 2 in-network deductibles do count toward each other (cross-accumulate). See the "Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum" section on page 2-17 for more information.

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

- "How the HSA Plan and Flex HDHP work" section starting on page 2-26
- "How the Copay Plan with HRA and Local Copay Plan with HRA work" section on page 2-15

The annual deductible is referred to as "deductible" in the cost-sharing tables starting on page 2-47.

The following do not count toward the annual deductible:

- Copays for prescription drugs
- Copays paid under the Copay Plan with HRA and the Local Copay Plan with HRA
- 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, billed by out-of-network providers in accordance with federal law
- 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, in the following circumstances:
  - 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 2-114 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. However, for the Copay Plan with HRA, the Tier 1 and Tier 2 in-network charges that apply to the out-of pocket maximums do count toward each other (cross-accumulate). See the "Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum" section on page 2-17 for more information.

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 HSA Plan and Flex HDHP work" section starting on page 2-26
- "How the Copay Plan with HRA and Local Copay Plan with HRA work" section starting on page 2-15

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, 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

For 2026, the individual out-of-pocket maximum is not applicable as the family limit is less than the individual maximum of $10,600.

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 2-43 and the "Prescription drug benefit" section starting on page 2-112.

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 tables starting on page 2-47, and the "Prescription drug benefit" section starting on page 2-112 for services subject to a copay. For the Copay Plan with HRA and the Local Copay Plan with HRA, you do not need to meet the annual deductible before the copay applies. But for the HSA Plan 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 and Local Copay Plan with HRA work

The Copay Plan with HRA and Local Copay Plan with HRA have an associated Health reimbursement arrangement (HRA) to help you pay for eligible expenses for covered health services. For more information, see the "Health reimbursement arrangement (HRA)" section starting on page 2-19, the "Covered health services definition" section starting on page 2-43, and the "Eligible expenses (allowed amount) definition" section starting on page 2-44. Below is additional information to help you understand how the plans work depending on whether you receive services from in-network or out-of-network providers. It's important to remember the Local Copay Plan with HRA does not provide coverage for services received from out-of-network providers, except for emergency care.

- 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. See the cost-sharing tables starting on page 2-47 for more information on copays. Refer to the "Prescription drug benefit" section starting on page 2-112 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 2-47, and in the "Prescription drug benefit" section starting on page 2-112. For more information on the applicable annual deductible, see the "Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum" section on page 2-17 and the "The Local Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum" on page 2-18.
- After you satisfy the applicable annual deductible:
  - For the Copay Plan with HRA in-network and Out of Area coverage, you will typically pay coinsurance for your share of eligible expenses for most covered health services received.
    - Tier 1: 10% coinsurance
    - Tier 2: 30% coinsurance
  - For the Local Copay Plan with HRA in-network services, you will typically pay 10% coinsurance for your share of eligible expenses for most covered health services received outside of an office visit.
  - For the Copay Plan with HRA out-of-network services, you will typically pay 50% coinsurance for your share of eligible expenses for most covered health services. **Note:** There is no out-of-network coverage for the Local Copay Plan with HRA (except for emergency care).
  - For prescription drugs, under both the Copay Plan with HRA and Local Copay Plan with HRA you will pay the applicable prescription drug copay.

Refer to the "Services covered under the medical plans" section starting on page 2-46 and the corresponding cost-sharing tables starting on page 2-47 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 2-112 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, except for covered emergency services).
- 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 2-40.
  - 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 2-10.

- For the Copay Plan with HRA only, 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 2-40) 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 2-107 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.
  - In some situations, 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 unless prohibited by federal law. The difference between the out-of-network provider's billed charges and the eligible expense (allowed amount) is generally 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.
- For both the Copay Plan with HRA and the Local Copay Plan with HRA, you pay:
  - 100% for expenses above those considered eligible expenses by the plan
  - 100% for services and expenses not covered by the plan

Copay Plan with 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 2-112 for information about how prescription drugs are covered. There is no tiering of providers for services such as Mental Health, Durable medical equipment, Hearing Aid, Acupuncture, Chiropractic, Physical Therapy/Occupational Therapy/Speech Therapy. For a full list, please contact UnitedHealthcare. When you see an in-network provider for these services, they will be covered at the Tier 1 copays and apply to the Tier 1 deductible, coinsurance, and out-of-pocket maximum amounts.

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[2]**	**Out-of-network providers**	**Out of Area[3] coverage**
You	Tier 1: $1,000 Tier 2: $1,600	$3,200	$1,000
You + spouse[1]	Tier 1: $1,500 Tier 2: $2,500	$5,000	$1,500
You + children	Tier 1: $1,400 Tier 2: $2,100	$4,200	$1,400
You + spouse[1] + children	Tier 1: $1,900 Tier 2: $3,000	$6,000	$1,900

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.
2. Tier 1 and Tier 2 deductible amounts cross-accumulate. For example, if you have You only coverage, haven't yet met your annual deductible, and receive a covered health service from a Tier 1 provider that costs you $250, that $250 will count toward your Tier 1 in-network annual deductible of $1,000 and that same $250 will also count toward your Tier 2 in-network annual deductible of $1,600. Similarly, if you see a Tier 2 provider, the amount you pay toward your Tier 2 in-network annual deductible will also be applied to your Tier 1 in-network annual deductible amount until the Tier 1 in-network annual deductible has been met. After the Tier 1 in-network annual deductible has been met, no additional Tier 1 expenses will apply to the Tier 2 annual deductible.
3. 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[2]**	**Out-of-network providers**	**Out of Area[3] coverage**
You	Tier 1: $3,150 Tier 2: $4,500	$9,000	$3,150
You + spouse[1]	Tier 1: $4,750 Tier 2: $7,250	$15,500	$4,750
You + children	Tier 1: $4,250 Tier 2: $6,250	$12,500	$4,250
You + spouse[1] + children	Tier 1: $6,050 Tier 2: $8,750	$17,500	$6,050

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.
2. Tier 1 and Tier 2 out-of-pocket amounts cross-accumulate. For example, if you have You only coverage, haven't yet met your annual out-of-pocket maximum and have a hospitalization at a Tier 1 hospital that costs you $1,500 out of pocket for covered health services, that $1,500 will count toward your Tier 1 in-network annual out-of-pocket maximum of $3,150 and that same $1,500 will also count toward your Tier 2 in-network annual out-of-pocket maximum of $4,500. Similarly, if you see a Tier 2 provider, the amount you pay toward your Tier 2 in-network annual out-of-pocket maximum will also be applied to your Tier 1 in-network annual out-of-pocket maximum amount until the Tier 1 in-network annual out-of-pocket maximum has been met. After the Tier 1 in-network annual out-of-pocket maximum has been met, no additional Tier 1 expenses will apply to the Tier 2 annual out-of-pocket maximum.
3. 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 2-31 for more information.
You	Up to $800
Your covered spouse[1]	Up to $400

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

The Local Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the Local Copay Plan with HRA and are subject to the procedures, exclusions, and limitations in this chapter. Covered services are described in the "What the medical plans cover" section beginning on page 2-43. **Refer to the "Prescription drug benefit" section starting on page 2-112 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 the "Emergency care" section on page 2-66 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	$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 2-31 for more information.
You	Up to $800
Your covered spouse*	Up to $400

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

Health reimbursement arrangement (HRA)

If you enroll in the Copay Plan with HRA or the Local 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 "General information about health and wellness activities" section starting on page 2-31.

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 or the Local 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 or the Local 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 HRA: Annual deductible and annual out-of-pocket maximum" table on page 2-17 and "The Local Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum" table on page 2-18.

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 this page. **Note: New starting January 1, 2026,** if you have both an HRA and a Full-Purpose Health Care FSA during the same plan year, new rules apply when paying for eligible expenses. For more information see the "Coordination of HRA and Full-Purpose Health Care FSA" section on page 2-21.
- 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 or the Local Copay Plan with HRA) and you do not elect COBRA continuation coverage in the Copay Plan with HRA or the Local Copay Plan with HRA, as applicable.
- You will forfeit all amounts allocated to your HRA if your Copay Plan with HRA or your Local 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 or the Local Copay Plan with HRA, you can keep track of the available balance in your HRA by going online to www.healthequity.com or by calling the number on the back of your HealthEquity® Visa® Card.

Using your HRA dollars

If you are enrolled in the Copay Plan with HRA or the Local Copay Plan with HRA, your HRA dollars are administered by HealthEquity. To use your available HRA dollars, you can pay for eligible medical and pharmacy expenses using your HealthEquity® Visa® Card or 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 last year while covered under the Copay Plan with HRA or Local Copay Plan with HRA, you would have until June 30 this year to submit the expense for HRA payment or reimbursement consideration. Expenses submitted after this deadline cannot be paid or reimbursed from the HRA.

Note: New starting January 1, 2026, if you have both an HRA and a Full-Purpose Health Care FSA during the same plan year, new rules apply when paying for eligible expenses. For more information see the "Coordination of HRA and Full-Purpose Health Care FSA" section on page 2-21.

Receiving your Card

When you are enrolled in the Copay Plan with HRA or the Local Copay Plan with HRA, you will automatically receive a HealthEquity® Visa® Card (Card) within two weeks of your enrollment date or early the following year if you enroll during Annual Benefits Enrollment (if you do not receive your Card, contact HealthEquity). You may request additional Cards for a spouse or adult-aged (18 or older) eligible dependents by visiting www.healthequity.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 gives you a convenient way to pay for eligible medical and pharmacy expenses directly using your HRA dollars. Read the Terms and Conditions of Use that you receive with your card before using the Card; the Terms and Conditions of Use are not a part of this SPD.

Replacement Cards, forgotten or stolen PINS, and disputed transactions

Call HealthEquity at 1-877-924-3967 immediately if your Card is lost or stolen or if you believe that someone has gained unauthorized access to your PIN. You can also call this number if

you forget your PIN or have additional questions about the Card. If you wish to dispute a transaction, see the Terms and Conditions of Use included with your Card for more information on your right to dispute a Card transaction.

Using the Card to pay for eligible expenses

You can use the Card to pay for eligible medical and pharmacy expenses covered by the Copay Plan with HRA or Local Copay Plan with HRA. The Card is generally accepted at pharmacies, doctors' offices, and hospitals that accept Visa® or NYCE Cards. Refer to the Terms and Conditions of Use included with your Card for information on the different terms that apply when a transaction is processed as a Visa debit transaction or as a NYCE transaction.

- Your Card can only be used to pay exact amounts you owe for eligible expenses. If your bill includes ineligible expenses, you must pay for those items separately with another form of payment.
- You can use the Card to pay a bill for eligible medical or pharmacy expenses. Write the Card number on your statement and send it back to the provider. Payment will be taken directly from available funds in your HRA as applicable and paid to the health care provider for eligible expenses.
- For mail-order prescriptions under the Copay Plan with HRA or Local Copay Plan with HRA, 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 HRA and paid to the mail-order company for your prescription drug copay.
- **New starting January 1, 2026,** if you have both an HRA and a Full-Purpose Health Care FSA during the same plan year, new rules apply when paying for eligible expenses. For more information see the "Coordination of HRA and Full-Purpose Health Care FSA" section on page 2-21.

When using your Card, keep the following in mind:

- Every time you swipe the Card, you certify that the expense that you are paying for with the Card is an eligible medical or pharmacy expense under the Copay Plan with HRA or Local Copay Plan with HRA and that you have not been reimbursed from any other source (e.g., other health insurance) and that you will not seek reimbursement from another source. Failure to abide by this certification will result in termination of Card use privileges.
- Use of the Card for eligible medical and pharmacy expenses is limited to merchants identified by HealthEquity as having a medical merchant category code, certain pharmacies that meet IRS requirements for Card use, and merchants that are participating in the Inventory Information Approval System (as defined by the IRS). If you have questions about whether the Card will work at a specific merchant, contact HealthEquity.
- You must obtain a third-party statement (EOB from your medical claims administrator or a claim details summary from Express Scripts) that includes information verifying that the expense was for an eligible medical or pharmacy expense. This statement provides substantiation required by the IRS that the expense is for an eligible medical or pharmacy expense. You should retain this statement for at least one year following the close of the plan year in which the expense is incurred. In accordance with IRS guidance, some of the expenses that you pay for with the Card will not require additional substantiation. However, many expenses that you pay for with the Card will require additional substantiation as required by the IRS.

It is your obligation to regularly check to see if you have any Card transactions that need verification; access your account at www.healthequity.com. 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. 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 are unable to provide adequate or timely substantiation as requested by HealthEquity, your Card privileges will be suspended until the correction process is completed (even if the correction is not completed until a subsequent plan year). Under the correction process, you must repay the plan for the unsubstantiated expense. You can either repay the plan with your own funds or, if eligible medical expenses are submitted for reimbursement, those expenses will be offset by the amount of any unsubstantiated claims. You generally must submit the required documentation or repay the unsubstantiated transaction by the claims filing deadline for the plan year. If you have not repaid the amount or if the amount is not offset by other eligible expenses, then the amount may be withheld from your pay (as specified in the Cardholder Agreement and as permitted by applicable law) or the remaining unpaid amount may be treated by Wells Fargo in accordance with IRS guidelines, which may result in additional gross income for you.

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 or the Local Copay Plan with HRA, as applicable, for the participant, a covered spouse, covered domestic partner, or covered child. A list of eligible expenses can be accessed at **www.healthequity.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 or the Local 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 (or the Local Copay Plan with HRA) at the time the expense is incurred.

Keep your eligible expense documentation

Keep the EOB from your medical claims administrator and the claim details summary from Express Scripts. HealthEquity may contact you to submit proof to verify that an expense is eligible. If you are not able to produce the required documentation 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** www.healthequity.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 required documentation is not sent in the time frame indicated by HealthEquity, your Card may be suspended until the issue is resolved. If your Card is suspended, see "Card suspensions" starting on page 2-23 for more information.

Coordination of HRA and Full-Purpose Health Care FSA

If you are enrolled in both the Full-Purpose Health Care Flexible Spending Account (FSA) and either the Copay Plan with HRA or the Local Copay Plan with HRA, you will receive one Card to use with both accounts (HRA and FSA). **Starting January 1, 2026, there are new rules regarding how your HRA and Full-Purpose Health Care FSA balances will be applied to pay for eligible medical and pharmacy expenses.**

- **When does the Full-Purpose Health Care FSA pay first?**

  New starting January 1, 2026:

  - If you have both an HRA and a Full-Purpose Health Care FSA during the same plan year, your eligible medical and pharmacy expenses under the Copay Plan with HRA or Local Copay Plan with HRA (and over-the-counter medicines, dental, and vision expenses) **will pay first from the Full-Purpose Health Care FSA until your Full-Purpose Health Care FSA funds are exhausted.**
  - When Full-Purpose Health Care FSA funds are completely exhausted, any available HRA balance will then be applied to eligible medical and pharmacy expenses covered by the Copay Plan with HRA or the Local Copay Plan with HRA. **Note:** HRA funds cannot be used to pay for expenses of a dependent who is not enrolled in the Copay Plan with HRA or the Local Copay Plan with HRA at the time the expense is incurred.

- **When does the HRA pay first?**

  New starting January 1, 2026:

  - If your Full-Purpose Health Care FSA funds are completely exhausted, any available HRA dollars will then be applied to your share of eligible medical and pharmacy expenses covered by the Copay Plan with HRA or the Local Copay Plan with HRA, as applicable. **Note:** HRA funds cannot be used to pay for expenses of a dependent who is not enrolled in the Copay Plan with HRA or the Local Copay Plan with HRA at the time the expense is incurred.

Coordination of HRA and Limited Dental/Vision FSA

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

- **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 or Local Copay Plan with HRA. **Note:** HRA funds cannot be used to pay for expenses of a dependent who is not enrolled in the Copay Plan with HRA or the Local Copay Plan with HRA at the time the expense is incurred.

Terminating coverage in the Copay Plan with HRA or the Local Copay Plan with HRA

If your medical coverage in the Copay Plan with HRA or the Local 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® Visa® Card HRA transactions" section below).

If your medical coverage in the Copay Plan with HRA or the Local 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® Visa® Card HRA transactions" section on this page).

Non-HealthEquity® Visa® 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 **www.healthequity.com**, and upload your scanned supporting expense documentation for your claim submission. This documentation may include, but is not limited to, an explanation of benefits (EOB).
- You can use the HealthEquity mobile app. 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:

  Claims Administrator
  HealthEquity
  PO Box 14053
  Lexington, KY 40512

You can download a claim form from **www.healthequity.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

Note: An explanation of benefits (EOB) is the only supporting documentation that will be accepted for HRA reimbursement for eligible medical expenses.

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 in the following order, as shown in Workday under View All Apps > Pay > Payment Elections:

1. Balance account;
2. Account with largest percent if no balance account;
3. Top row if no balance account but percentages are equal.

If you receive your pay by check, you'll receive your reimbursement by check.

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" when you access your account at www.heatlhequity.com 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

Access your account online to review and print your real-time account information at any time.

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. 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 www.healthequity.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.
- **No (Further) Action Required**. HealthEquity was able to resolve this amount without further action required from you, based on information you submitted to HealthEquity.
- **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 www.healthequity.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 eligible expense documentation or substitute documentation 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 or the Local 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 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 (Tier 1) and $1,600 (Tier 2)
- In-network annual out-of-pocket maximum of $3,150 (Tier 1) and $4,500 (Tier 2)
- 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 or the Local 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 or the Local Copay Plan with HRA that you enrolled in. If you are changing from a Kaiser medical plan option to the Copay Plan with HRA or the Local 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 or the Local 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 or the Local Copay Plan with HRA. The information above also applies to a covered dependent of an employee who enrolls in the Copay Plan with HRA or the Local Copay Plan with HRA midyear as a COBRA-qualified beneficiary.

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 Wells Fargo & Company 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 or the Local 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 (Tier 1) and $1,600 (Tier 2)
- In-network annual out-of-pocket maximum of $3,150 (Tier 1) and $4,500 (Tier 2)
- 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 (or the Local Copay Plan with HRA) during a rehire enrollment period, the following will be applied to your Copay Plan with HRA (or the Local 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 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 or the Local 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, and you had coverage under the Retiree Plan immediately preceding your date of rehire.

Your medical plan coverage under the Health Plan is effective on your date of rehire.

If you have Retiree Health Reimbursement Arrangement (RHRA) coverage under the Wells Fargo & Company Retiree Plan, your RHRA allocations will be suspended and you may not be reimbursed from your RHRA for any premium expenses for the time you are rehired by Wells Fargo. Once you are retired again, your RHRA coverage will be reinstated and your allocations will begin again under the RHRA plan.

You may be covered under another medical and prescription drug plan when you are rehired by Wells Fargo, and the plan may be another group plan or an individual plan. When you enroll in the Wells Fargo & Company Health Plan (Health Plan) as a rehire, the Health Plan's medical and prescription drug may overlap with other coverage you may have. During any overlap period where you may have coverage under more than one plan, the Health Plan is the primary plan. This means that health care providers and pharmacies should submit claims first to the Health Plan and second to any other plans you may have during your overlap period.

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 or Local 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 or Local Copay Plan with HRA, as applicable. If you are changing from a Kaiser medical plan option to the Copay Plan with HRA or Local 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 or Local 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 $200 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 or Local Copay Plan with HRA, as applicable, 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 (or Local Copay Plan with HRA) COBRA continuation coverage is in effect without a gap in coverage.

If you elect the same level of COBRA continuation coverage that you had 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 COBRA continuation coverage for the same plan year. If you do not elect the same level of coverage you had as an employee, your annual deductible and annual out-of-pocket maximum will be adjusted (but 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 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 or your Local Copay Plan with HRA and elects Copay Plan with HRA COBRA continuation coverage or Local Copay Plan with HRA COBRA continuation coverage, as applicable, 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 or Local Copay Plan with HRA COBRA continuation coverage, as applicable, for the same plan year. Other benefit limits will not be transferred and will start over under your new claims administrator. Also see the "HRA dollars, annual deductible, and annual out-of-pocket maximum for midyear enrollments" section starting on page 2-23 for other information related to a midyear enrollment.

Your dependent will also be credited with an HRA balance under the Copay Plan with HRA COBRA continuation coverage or Local Copay Plan with HRA COBRA continuation coverage, as applicable, 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 or your Local Copay Plan with HRA coverage. For example:

- An employee covers their spouse as a dependent under the Copay Plan with HRA for the 2024 plan year. The employee and spouse divorce on August 10, 2024, and the former spouse's coverage ends effective August 31, 2024. If your HRA balance on August 31, 2024 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 2024 plan year. The child turns age 26 on May 15, 2024, and the child's coverage ends effective May 31, 2024. If your HRA balance on May 31, 2024 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 or the Local Copay Plan with HRA COBRA continuation coverage, as applicable, for any individual who elects (or is covered as a dependent under) COBRA continuation coverage. Other benefit limits will not be transferred and will start over under your new claims administrator.

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 Local 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.

Within thirty days of your effective date with your new claims administrator, your prior claims administrator will automatically transfer amounts applied to your annual deductibles, annual out-of-pocket maximums, and lifetime benefits accruals for infertility and fertility services and treatment for the current plan year. Other benefit limits will not be transferred and will start over under your new claims administrator.

If you terminate employment and choose COBRA continuation coverage for the applicable Copay Plan with HRA or Local Copay Plan with HRA, as applicable, 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 (home) 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, Kaiser POS, or the Local Copay Plan with HRA). If you elect to enroll in the Copay Plan with HRA midyear as a result of your change in home address, please refer to the "HRA dollars, annual deductible, and annual out-of-pocket maximum for midyear enrollments" section starting on page 2-23 for more information.

If you have a change in home 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 home 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 or Local 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 2-23 for more information.

If you are enrolled in the Copay Plan with HRA or Local 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 applicable Copay Plan with HRA or the Local 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 or the Local Copay Plan with HRA" starting on page 2-21.

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

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. If you would like more information when you retire, refer to the Planning to Retire Guide on the HR Services & Support site.

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 2-24.

For information regarding your HRA balance, see the "Terminating coverage in the Copay Plan with HRA or the Local Copay Plan with HRA" starting on page 2-21.

How the HSA Plan and Flex HDHP work

The HSA Plan is a high-deductible health plan that is compatible with a health savings account (HSA) and is available nationwide to regular and fixed term employees, except in the state of Hawaii.

- Your HSA 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 2-31.

The Flex HDHP is also a high-deductible health plan that is only available to interns and flexible employees. If you are an intern or flexible employee and enroll in the Flex HDHP, Wells Fargo will not open 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).

Both the HSA Plan and the Flex HDHP cover eligible expenses for covered health services. (See the "Covered health services definition" section starting on page 2-43 and the "Eligible expenses (allowed amount) definition" section starting on page 2-44 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 starting on page 2-47 and for "prescription drugs", see page 2-112 for information about what you will pay for prescription drugs. For more information on the applicable annual deductible, see the "Health Savings Account (HSA) Plan and Flexible High Deductible Health Plan (Flex HDHP): Annual deductible and annual out-of-pocket maximum" section on page 2-28.
- 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 prescription drug copay.

Refer to the "Services covered under the medical plans" section on page 2-46 and the corresponding cost-sharing tables starting on page 2-47 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 2-112 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, except for covered emergency services).

- 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 2-40.
  - 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 2-10.

- Additional information about services received from out-of-network providers:
  - 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 2-40) 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 2-107). 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. In some situations, 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 unless prohibited by federal law. The difference between the out-of-network provider's charges and the eligible expense (allowed amount) under the medical plan is generally 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.

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

These amounts apply to individuals enrolled in the HSA plan and the Flex HDHP, and are subject to the procedures, exclusions, and limitations in this chapter. **Refer to the "Prescription drug benefit" section starting on page 2-112 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	$3,250	$6,500	$3,250
You + spouse[1]	$5,200	$10,400	$5,200
You + children	$4,250	$8,500	$4,250
You + spouse[1] + children	$6,200	$12,400	$6,200

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.
2. Out-of-area coverage only applies to the HSA Plan. 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	$5,500	$11,000	$5,500
You + spouse[1]	$8,800	$15,400	$8,800
You + children	$7,200	$12,600	$7,200
You + spouse[1] + children	$10,400[3]	$18,200	$10,400[3]

1. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.
2. Out-of-area coverage only applies to the HSA Plan. 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 $10,400 in eligible medical and prescription drug expenses for the annual out-of-pocket maximum.

HSA Plan only **Health and wellness**	**Your available health and wellness dollars[1]** See the "Health and wellness activities" section starting on page 2-31 for more information.
You	Up to $800
Your covered spouse[2]	Up to $400

1. Employees enrolled in the Flex HDHP are not eligible for health and wellness dollars.
2. For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.

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

If you enroll midyear in the HSA 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. 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 $3,250
- In-network annual out-of-pocket maximum of $5,500

If you enroll midyear in the HSA Plan, you would also be 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, but you are not eligible for 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 annual out-of-pocket maximum. If you enroll in the HSA Plan 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 HSA Plan or the Flex HDHP. If you are changing from a Kaiser medical plan option under the Health Plan to the HSA Plan or 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 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 the HSA Plan or the Flex HDHP. The information above also applies to a covered dependent of an employee who enrolls in the HSA Plan or the Flex HDHP midyear as a COBRA-qualified beneficiary.

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 Wells Fargo & Company Health Plan ("Health Plan") immediately preceding your rehire date.

If you had continuous COBRA medical coverage and you enroll in the HSA Plan 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 HSA Plan under COBRA medical coverage and, as a rehire, you enroll midyear in the HSA 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 $3,250
- In-network annual out-of-pocket maximum of $5,500
- Eligible to earn up to $400 in health and wellness dollars

As a rehired employee who had continuous COBRA medical coverage and enrolled in the HSA Plan or the Flex HDHP 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 applicable HSA Plan or Flex HDHP 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 you enroll in your HSA Plan or Flex HDHP under the Health Plan as a rehired employee).
- 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, and you had retiree medical coverage under the Retiree Plan immediately preceding your date of rehire.

Your medical plan coverage under the Health Plan is effective on your date of rehire.

If you have Retiree Health Reimbursement Arrangement (RHRA) coverage under the Wells Fargo & Company Retiree Plan, your RHRA allocations will be suspended and you may not be reimbursed from your RHRA for any premium expenses for the time you are rehired by Wells Fargo. Once you are retired again, your RHRA coverage will be reinstated and your allocations will begin again under the RHRA plan.

You may be covered under another medical and prescription drug plan when you are rehired by Wells Fargo, and the plan may be another group plan or an individual plan. When you enroll in the Wells Fargo & Company Health Plan (Health Plan) as a rehire, the Health Plan's medical and prescription drug may overlap with other coverage you may have. During any overlap period where you may have coverage under more than one plan, the Health Plan is the primary plan. This means that health care providers and pharmacies should submit claims first to the Health Plan and second to any other plans you may have during your overlap period.

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 HSA Plan or the Flex HDHP 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 HSA Plan or the Flex HDHP, as applicable. If you are changing from a Kaiser medical plan option under the Health Plan to the HSA Plan or 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 applicable HSA Plan or Flex HDHP 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 HSA Plan 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 $200 for completing all health and wellness activities during the plan year.

COBRA enrollment

Former or ineligible employees who elect COBRA

If you are eligible for and elect COBRA continuation coverage for the HSA Plan or the Flex HDHP during your initial COBRA enrollment period at the same level of coverage you had under the HSA Plan 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 HSA Plan 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.

Dependents who elect COBRA

If your dependent is no longer eligible for coverage under your HSA Plan 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 2-29 for other information related to a midyear enrollment.

Lifetime benefit accruals transfer under COBRA

Lifetime benefits accruals for infertility and fertility services and treatment will transfer to the HSA Plan or the Flex HDHP, as applicable, under COBRA continuation coverage for any individual who has COBRA continuation coverage. Other benefit limits will not be transferred and will start over under your new claims administrator.

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 HSA Plan 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 HSA Plan 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 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 in 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 and filed within the required claims filing period.
- Within thirty days of your effective date with your new claims administrator your prior claims administrator will automatically transfer amounts applied to your annual deductibles, annual out-of-pocket maximums, and lifetime benefits accruals for infertility and fertility services and treatment for the current plan year

Other benefit limits will not be transferred and will start over under your new claims administrator.

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 (home) 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, Kaiser POS, or the Local Copay Plan with HRA). If you elect to enroll in the HSA Plan or the Flex HDHP midyear as a result of your change in home address, please refer to the "Annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments" starting on page 2-29 for more information.

If you have a change in home 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" starting 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 home 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 the HSA Plan or the 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 2-29 for more information.

As a regular or fixed term employee, if you are enrolled in the HSA Plan 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, Local Copay Plan with HRA, HMO — Kaiser, or Kaiser POS, your coverage under the HSA Plan 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 terminate employment, retire, become ineligible for coverage, or drop coverage

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. If you would like more information when you retire, refer to the Planning to Retire Guide on the HR Services & Support site.

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 HSA Plan or the Flex HDHP, see the "COBRA enrollment" section starting on page 2-30.

If you do not elect COBRA continuation coverage for the HSA Plan 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 the HSA Plan 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.

Health and wellness activities

General information about 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. See the "Health and wellness activities table" on page 2-34 and the "Health and wellness activity descriptions" section starting on page 2-34 for information about the available health and wellness activities under the program.

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. Also see the "Protections from Disclosure of Medical Information" section on page 2-36.

Optum is the administrator of all health and wellness activities. Participation in activities is completely voluntary and is facilitated through Optum Engage. You may receive a phone call from Optum, Optum Engage, or your medical plan's claims administrator to invite you to participate in one or more of the activities. Access to Optum Engage is provided through wellness.myoptumhealth.com, the Optum Engage 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.

If you are enrolled in certain Wells Fargo-sponsored medical plans, you may be eligible to earn health and wellness dollars for

the activities you complete (see the "Who's eligible for health and wellness dollars" section starting on this page and the "Earning health and wellness dollars" section on this page for more information). Optum Engage will help you monitor completion of these activities and the health and wellness dollars you've earned.

Health and wellness dollars may be used for eligible medical expenses, but only after the health and wellness dollars have been deposited to your health savings account (HSA) or allocated to your health reimbursement arrangement (HRA), as applicable. Amounts are deposited or allocated as soon as administratively feasible.

Medical premium tobacco surcharge credit

If you have identified yourself as a tobacco user, you are required to pay a premium surcharge for Wells Fargo medical plan coverage (this applies to all medical plan coverage options). However, if you enroll in the company-sponsored tobacco cessation program called Quit For Life®, you will qualify to receive a full or prorated tobacco surcharge credit. This program is completely voluntary and is offered at no additional charge as part of the wellness program. For more information see the "Quit For Life®" section on page 2-36.

Who's eligible for health and wellness dollars

To be eligible to earn health and wellness dollars, you must be enrolled in one of the following Wells Fargo-sponsored medical plan options: HSA Plan, the Copay Plan with HRA, or the Local Copay Plan with HRA. Your covered spouse or domestic partner also has an opportunity to earn health and wellness dollars to be deposited to your health savings account or allocated to your health reimbursement arrangement, as applicable. **Note:** Health and wellness dollars are not available to participants of the HMO — Kaiser medical plans, or POS Kaiser Added Choice — Hawaii or the Flex HDHP plan.

Additional information about eligibility for health and wellness dollars:

- Your coverage (and coverage for your spouse or domestic partner, if applicable) must be effective under the HSA Plan, the Copay Plan with HRA, or the Local Copay Plan with HRA at the time the health and wellness-related activity is completed.
  - You are also eligible to earn health and wellness dollars if you have elected COBRA coverage under one of those medical plans or are on an approved leave of absence. **Note:** 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 for the same plan year.
- 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 or earn health and wellness dollars regardless of age.
  - 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.
- You and your covered spouse or domestic partner (or adult dependent child with their own COBRA coverage) are not eligible for health and wellness dollars for repeating the activities or programs during this same plan year, unless otherwise specified.

Earning health and wellness dollars

The amounts stated in the table below reflect the maximum amount of health and wellness dollars you can earn for deposit in your HSA or allocated to your HRA, as applicable, upon completion of specified health and wellness activities if you are eligible. See the "Health and wellness activities table" on page 2-34 for more information about amounts associated with the available 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 $400 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 as noted in the table below.

Benefit effective date occurs during:	Maximum health and wellness dollars*	
	Employee	Spouse or domestic partner
Quarter 1 (January – March)	$800	$400
Quarter 2 (April – June)	$600	$300
Quarter 3 (July – September)	$400	$200
Quarter 4 (October and November)	$200	$100

* See the "Deadline for earning health and wellness dollars" section on page 2-33 for more information.

In certain cases, the above 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).

The following also applies to the HRA allocations or HSA deposit, as applicable, for earned health and wellness dollars:

- For the earned health and wellness dollars to be allocated to your health reimbursement arrangement, you must be a participant in the Copay Plan with HRA or Local Copay Plan with HRA at the time the activity is completed.
- For the earned health and wellness dollars to be deposited into your Optum health savings account (HSA):
  - You must be a participant in the HSA 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.
    - 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 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.
- Eligible earned amounts are deposited to your HSA or allocated to your HRA as soon as administratively feasible.

Deadline for earning health and wellness dollars

- **For most health and wellness activities**, generally, you must complete the activity between January 1 and November 15 of the current plan year to earn health and wellness dollars for the current plan year.
  - For example, if you complete an online health survey on November 14, 2026, and are otherwise eligible, you will earn health and wellness dollars for 2026.
  - Generally, if you complete a health and wellness activity on November 16, 2026, you will not receive health and wellness dollars for 2026.
- **For a biometric screening completed at your physician's office**, not only must you complete the screening by November 15 of the current plan year, you must also submit a completed and signed physicians results form by November 15 of the current plan year. See the "Biometric screenings" section on page 2-34 for more information on this and other biometric screening options.
- **Annual exams, dental check-ups, and preventive care exams completed between November 16 and December 31** of the current plan year may be eligible for applicable health and wellness dollars in the following plan year, but only if you complete your attestation on Optum Engage by November 15 of the following plan year and you are otherwise eligible. For example, if you have your dental check-up on December 1, 2026, you are not eligible for health and wellness dollars in 2026. You may be eligible to receive applicable health and wellness dollars for that check-up if you provide your attestation in 2027 but you must still be enrolled in an eligible medical plan in 2027.

Health and wellness activities table

The list below is subject to change. Check the Optum Engage site at wellness.myoptumhealth.com for an up-to-date list of activities and incentive amounts. Completion of activities below is subject to the information stated in the "Who's eligible for health and wellness dollars" section on page 2-32, the "Earning health and wellness dollars" section on page 2-32, and the "Deadline for earning health and wellness dollars" section on page 2-33.

Activity	Action	Dollar amount
Optum Engage Health Survey The Optum Engage health survey can help you identify lifestyle risks, reinforce healthy habits, and learn about resources to improve your health.	Complete the health survey	$50
Included Health expert medical opinion	Complete an expert medical opinion with Included Health	$150
Employee Assistance Program (EAP) video	Watch a video about EAP	$50
Biometric Screening A biometric screening will check your blood pressure, cholesterol, and other health indicators.	Complete a biometric screening	$150
Diabetes Management* program (Livongo)	Complete four blood sugar checks with the connected meter over two consecutive months	$300
Preventive Care Exams Annual physical	Complete your annual physical	$300
Preventive Care Exams Complete your routine preventive screenings.	Choose from the following: • Cervical screening • Mammogram • Prostate exam • Colonoscopy, sigmoidoscopy, or Cologuard®	$150 each
Stride (monitored physical activity)	Meet your step goal 12 or more times in the month	$25/month (up to $275)
Weight Management* program (Real Appeal) See page 2-35 for eligibility details.	Complete nine sessions	$300
Dental Check-up Complete your preventive dental exam with your dental provider.	Complete a dental check-up	$100

Health and wellness activity descriptions

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; the wellness program is voluntary. However, only employees who complete the activities will receive health and wellness dollars, if otherwise eligible. The activities listed are subject to change. Check the Optum Engage site at wellness.myoptumhealth.com for an up-to-date list of activities and incentive amounts. Also see the "Who's eligible for health and wellness dollars" section on page 2-32, the "Earning health and wellness dollars" section on page 2-32, and the "Deadline for earning health and wellness dollars" section on page 2-33 for additional requirements and information.

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 Optum Engage website or mobile app. The mobile app should be used on personal devices only and should not be used on Wells Fargo-owned devices.

Biometric screenings

What is a biometric screening

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.

How to complete your biometric screening

Your biometric screening can be completed in one of the ways stated below. You must complete your screening between January 1 and November 15 of the current plan year while you are covered under the HSA Plan, the Copay Plan with HRA, or the Local Copay Plan with HRA. Biometric screenings completed November 16 – December 31 are not eligible for health and wellness dollars.

1. Receive your screening from your personal physician.
   a. For biometric screenings received from your physician, the medical provider must complete a physician results form and you or your physician will need to submit the completed and signed form to Optum/LetsGetChecked by the deadline stated in the "Deadline for submitting the completed and signed physician results form" section on this page.
      i. Get a copy of the required physician results form on the Optum Engage website by logging into your Optum Engage account at wellness.myoptumhealth.com. It is your responsibility to ensure that your provider completes the physician results form correctly and signs the form.
   b. While it is intended that a biometric screening you receive from your personal physician will be an eligible preventive care service under the HSA Plan, Copay Plan with HRA, and the Local Copay Plan with HRA, 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" section starting on page 2-88.
2. Make an appointment at a LetsGetChecked service center, if available in your area, to receive your screening.
   a. A physician results form is not needed at these locations.

Deadline for submitting the completed and signed physician results form

Your properly completed and signed physician results form must be submitted to Optum/LetsGetChecked by November 15 of the current plan year if you had your screening done by your physician. For example, if you want to earn health and wellness dollars for your 2026 biometric screening completed at your doctor's office, and you are otherwise eligible, you must submit your completed and signed physician results form to Optum/LetsGetChecked by November 15, 2026.

You may submit the completed signed form in one of the following ways:

- Upload it on the Optum/LetsGetChecked website
- Fax it to the number listed on the physician results form.

Forms uploaded or with a postmark or a fax received date after November 15 of the current plan year will not be accepted.

Preventive Care

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. The following are eligible preventive care activities under the health and wellness program; complete one or more to earn health and wellness dollars. The list may be subject to change.

- Annual physical
- Mammogram
- Colonoscopy, sigmoidoscopy, and Cologuard®
- Cervical screening
- Prostate exam

Stride

Stride is a movement program that allows you to select your own daily step goal. Achieve your goal 12 times in a month to earn your reward. You will set your own step goal. It can be as beginner friendly as 5,000 steps per day or up to 12,500. If you hit your goal consistently, Stride will encourage you with the option to increase your step goal. All types of physical activity or movement detected by your commercial step tracker or phone will count toward your daily step goal.

Important: Stride requires the Optum Engage mobile app. To participate, you need access to a personal smartphone. It is a violation of company policy to use a Wells Fargo device.

Real Appeal

Real Appeal is a digital weight loss program, available to eligible medical plan participants at no additional cost, 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 wf.realappeal.com or call Real Appeal at 1-844-924-7325. Adult dependents should call Optum Engage Support at 1-877-543-4294 to enroll.

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.* Livongo is not available to individuals enrolled in the Kaiser medical plans.

Quit For Life®

If you identify yourself as a tobacco user and you enroll in Quit For Life®, you will receive a tobacco surcharge credit prospectively, as soon as administratively feasible, for your Wells Fargo medical plan premium.

Quit For Life® is a comprehensive tobacco cessation program, that includes individuals who are using nicotine vaping devices as well as smokeless tobacco or chew tobacco. It provides a clear path to quitting and remaining nicotine-free, and includes online learning, free nicotine replacement therapy, and 24/7 coaching support. Call 1-866-784-8454 for more information on Quit For Life® or visit https://quitnow.net. (**Note:** The surcharge does not apply to the Flex HDHP or the Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance). The surcharge also does not apply to COBRA participants enrolled in any medical plan.)

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 arrangement (HRA) or deposited into your health savings account (HSA) contact the Optum Engage Support team at 1-877-543-4294 to open a case for investigation (an inquiry).

For previous plan year health and wellness dollars, you must open your case for investigation with Optum Engage via a phone call or through the Optum Engage portal no later than June 30 of the current plan year. Requests for previous year health and wellness dollars received later than June 30 of the current plan year will be denied.

- For example: For 2026 health and wellness dollars, you must open your case for investigation with Optum Engage via a phone call or through the Optum Engage portal no later than June 30, 2027. Requests for 2026 health and wellness dollars received later than June 30, 2027, will be denied.

The Optum Engage 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 Engage 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 HSA Plan, the Copay Plan with HRA, and the Local Copay Plan with HRA 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 accommodations form (find the form on the HR Services & Support site). For current plan year health and wellness dollars accommodations, the health provider accommodations form must be submitted no later than November 15 of the current plan year.
  - Example: You want to file a request for accommodations for 2026, the required form must be completed and submitted no later than November 15, 2026.
- If you're a designated tobacco user but you believe it's unreasonably difficult or medically inadvisable for you to enroll in the Quit For Life® tobacco cessation program, you and your physician can complete a request for accommodation form. If you and your physician complete and submit a request for accommodation form (find the form on HR Services & Support), you'll receive a tobacco surcharge credit for the Wells Fargo medical plan premium, if applicable, as soon as administratively feasible.

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, Optum Engage, 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 and the claims administrators for the HSA Plan, the Copay Plan with HRA, and the Local Copay Plan with HRA 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 wellness coaching, and web-based tools and resources, including online wellness education programs, through Wellos. Each of these is described in more detail below.

The medical claims administrators, Express Scripts, Optum, and Included Health 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 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.

Wellness Coaching

All U.S. based regular or fixed term employees can enroll in the Wellness Coaching program, regardless of if they are enrolled in a Wells Fargo medical plan. The Wellness Coaching program is provided through Wellos. Wellos is a wellness app made to support your journey toward a healthier lifestyle. With a focus on personalized coaching and smart technology, Wellos offers a well-rounded approach to help you achieve your health goals. Key features include 1:1 coaching support, meal planning, and enhanced tracking that teaches you about nutrition. With over 5,000 recipes tailored to your needs, Wellos makes healthy eating accessible and enjoyable. The program also supports behavior change, expert guidance, and a wealth of resources to help you build better habits and redefine your relationship with food. Try Wellos at www.wellos.com/member.

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, behavioral health support, and medication information. Call Included Health at 1-833-200-7683, option 2.

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.

Included Health Expert Medical Opinion

A second medical opinion is available through the Included Health Expert Medical Opinion service. These second opinions are at no cost and are available by video or phone. This additional medical information may help you make more informed decisions about your care.

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 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 UHC, certain outpatient surgeries).

Description	Included Health	Anthem BCBS	Centivo	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			
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	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
Included Health Expert Medical Opinion (a second medical opinion) Access a second medical opinion, at no additional cost, where you can get answers to your questions from medical experts through a video or phone consultation	X			
Maternity support Program to support normal and high-risk pregnancies		X	X	X
Medical Rx specialty management		X	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 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	X

Check with Included Health or 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 or the Local 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
- Nonemergency 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)
- 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 or the Local 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 –All of the following health care services as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion:

In accordance with *Generally Accepted Standards of Medical Practice*.

Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use-related and addictive disorders, 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(s), service site 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.

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 has 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 the 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 UnitedHealthcare's determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com.

If you are receiving services from an in-network provider, the provider is responsible to obtain the appropriate pre-service authorization prior to any procedure. If you are receiving services from an out-of-network provider, you are required to obtain pre-service authorization for the services listed below to ensure services meet coverage criteria.

- Ambulance (nonemergency ground or air services)
- Bariatric surgery (obesity surgery)
- Cardiology services/treatments
- Clinical trials
- Congenital heart disease
- Diabetes treatment: Insulin pump costing more than $1,000
- Durable medical equipment costing more than $1,000
- Gender dysphoria
- Genetic testing – BRCA
- Home health care – private-duty nursing
- Hospice – inpatient only
- Inpatient hospital: Nonemergency inpatient hospital, inpatient treatment, intensive outpatient, partial hospitalization, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care)
- Maternity services – if exceeds mandated length of stay
- Mental health care, substance use-related, and addictive disorders services
- Orthognathic surgery
- Prosthetic devices costing more than $1,000
- Radiology services
- Reconstructive procedures
- SNF/inpatient rehab
- Sleep apnea procedures and surgery
- Sleep studies: lab, X-ray and diagnostics
- Therapeutics (outpatient) – dialysis, IV infusion, intensity modulated radiation therapy, MR-guided focused ultrasound
- Transplant services

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: Nonemergency inpatient hospital, inpatient treatment, intensive outpatient, partial hospitalization, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care)
- 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

Certain services must be reviewed by Anthem BCBS to determine medical necessity in order for you to get benefits. For pre-service authorization contact Anthem BCBS at 1-866-418-7749 or by fax at 1-800-241-5308. The pre-authorization review includes the process of Utilization Review to decide when services are medically necessary or experimental or investigational as determined by Anthem BCBS.

Utilization Review criteria will be based on many sources, including Anthem BCBS medical policy and clinical guidelines. A service must be medically necessary and not experimental or investigational to be a covered service. Anthem BCBS may decide that a treatment that was asked for is not medically

necessary if a clinically equivalent treatment that is more cost-effective is available and appropriate. When the level of care, setting, or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting or place of care, as determined by Anthem BCBS, will not be considered medically necessary if those services are given in a higher level of care or higher cost setting or place of care and no benefits will be available.

If you have any questions regarding the information in this section, log in at anthem.com to chat with a representative or call 1-866-418-7749.

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
- Ambulance (nonemergency ground or air services)
- Bariatric procedures
- Carotid, vertebral, and intracranial artery angioplasty with or without stent placement
- Chimeric Antigen Receptor (CAR) T-Cell Therapy
- Certain spine and joint 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
- Gene therapy
- Genetic testing
- Home health care services
- Hospice care (inpatient only)
- Infertility and fertility services and treatments
- Inpatient hospital: Nonemergency inpatient hospital, inpatient treatment, intensive outpatient, partial hospitalization, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care)
- 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)" section starting on page 2-38)
- 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: Nonemergency inpatient hospital, inpatient treatment, intensive outpatient, partial hospitalization, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care)
- 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.

Centivo

Pre-service authorization is subject to Centivo medical policies located at centivo.com/wf. 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 Centivo, 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 Centivo.

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 centivo.com/wf 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.

- Ambulance (nonemergency ground or air services)
- Arthroscopy
- Bariatric procedures (obesity surgery)
- Chemotherapy
- Cosmetic surgery potentials:
  - Abdominoplasty
  - Blepharoplasty
  - Mammoplasty
  - Panniculectomy
  - Varicose veins stripping and ligation
- Dialysis
- Epidural (except related to childbirth)
- Extended nursing facility
- Facet and trigger point injections
- Genetic testing
- Home health care
- Joint surgery
- Implants of any type
- Infusion (infusion therapy) of any type > $3,000
- Injections or drugs above $1,500 a dose
- Inpatient hospital – Nonemergency inpatient hospital, inpatient treatment, intensive outpatient, partial hospitalization, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care)
- Inpatient rehabilitation
- Laminectomy/spinal surgery
- Long Term Acute Care (LTAC)
- Ongoing wound care
- Outpatient Intensive Mental Health or Substance Use Disorder – facility based programs
- PET scan
- Radiation treatments
- Residential treatment
- Skilled nursing facility

What the medical plans cover

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: 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 use, 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 their 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 are based on the following:

- When covered health services are received from a network provider, eligible expenses are our contracted fee(s) with that provider.
- When covered health services are received from a non-network provider the eligible expense is the amount determined by UnitedHealthcare in accordance with its internal policies and procedures.

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.

When non-emergency covered health services are received from out-of-network providers, your out-of-network provider may bill you for amounts above the eligible expense including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. These amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.

When using an out-of-network provider for emergency health services, you are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance, or deductible. The methodology for determining the eligible expense amount for out-of-network emergency services will comply with the requirements of federal law. See the "Surprise billing protections" section starting on page 2-102 for more information on the allowed amounts related to claims subject to surprise billing protections.

The plan has contracted with UnitedHealthcare to provide advocacy services on your behalf with respect to out of network providers that have questions about the eligible expenses and how UnitedHealthcare determined those amounts. Please call UnitedHealthcare at 1-800-842-9722 to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment.

Regardless of the network status of the provider, when a service or device for a functional impairment (defined as any abnormality of organ, or psychological function, or anatomical structure that leads to inability to perform normal activities), and UnitedHealthcare makes a determination that, although unproven, you or your provider have demonstrated that the service or device will significantly improve your quality of life, they may approve for it to be covered.

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.

- Providers who have not signed any contract with the claims administrator and are not in any of the claims administrator's networks are out-of-network providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. We will calculate the maximum allowed amount for covered services you receive from an out-of-network provider using 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.

  - The methodology for out-of-network emergency services will comply with the requirements of federal law with respect to out-of-network emergency services. See the "Surprise billing protections" section on page 2-102 for more information on the allowed amounts related to claims subject to surprise billing protections.

Centivo administered medical plans

Eligible expenses, also known as allowed amounts or eligible covered expenses are determined as follows:

- When covered health services are received from in-network providers, eligible expenses are the provider's discounted contracted fees.
- Centivo's reimbursement policy guidelines also apply. The reimbursement policy guidelines are developed, in Centivo'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 2-43 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, except in plans administered by Centivo.

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 2-14.

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 2-10.

Note: In limited circumstances, when there is no in-network provider, the claims administrator, in its sole discretion, may be able to discuss possible alternatives. Contact your claims administrator at the number on the back of your ID card.

Cost-sharing for outpatient office visits or urgent care visits

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
• **HSA Plan** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the annual deductible.	You pay 50% of eligible covered expenses after you satisfy the annual deductible.[2]	HSA Plan: You pay 20% of eligible covered expenses after you satisfy the annual deductible.[2] Flex HDHP: Out of Area coverage does not apply.
• **Copay Plan with HRA** This plan has a tiered in-network structure, for more information about the tiers, see the "Provider networks — general information" section on page 2-10 and the "UnitedHealthcare provider networks" "Copay Plan with HRA" section on page 2-11. **Note:** You may use available HRA dollars for your portion of eligible covered health expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	**Tier 1:** • You pay a $10 copay for convenience care office visit[3,4] • You pay a $20 copay for an office visit with a primary care physician.[3,4] • You pay a $40 copay for an office visit with a specialist provider.[3,4] • You pay a $50 copay for an urgent care visit.[3,4] • For services billed separately from the office visit charge or urgent care visit charge, you pay 10% of eligible covered expenses after you satisfy the Tier 1 annual deductible. **Tier 2:** • You pay a $20 copay for convenience care office visit[3,4] • You pay a $50 copay for an office visit with a primary care physician.[3,4] • You pay a $100 copay for an office visit with a specialist provider.[3,4] • For services billed separately from the office visit charge or urgent care visit charge, you pay 30% of eligible covered expenses after you satisfy the Tier 2 annual deductible.	You pay 50% of eligible covered expenses after you satisfy the annual deductible.[2]	• You pay a $10 copay for convenience care office visit[3,4] • You pay a $20 copay for an office visit with a primary care physician.[3,4] • You pay a $40 copay for an office visit with a specialist provider.[3,4] • You pay a $50 copay for an urgent care visit.[3,4] • For services billed separately from the office visit charge, you pay 10% of eligible covered expenses after you satisfy the Tier 1 annual deductible.[2]
• **Local Copay Plan with HRA**[5] **Note:** You may use available HRA dollars for your portion of eligible covered health expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	• You pay a $0 copay for an office visit with a primary care physician.[3,4] • You pay a $0 copay for Convenience Care office visit[3,4] • You pay a $0 copay for an office visit with a mental health or substance use provider. • You pay a $25 copay for an office visit with a specialist provider.[3,4] • You pay a $50 copay for an urgent care visit.[3,4] • For services billed separately from the office visit charge or urgent care visit charge, you pay 10% of eligible covered expenses after you satisfy the annual deductible.	No coverage **Note:** For Centivo only, you will pay the in-network copay for services from an out-of-network out-patient mental health visit. You may also be responsible for charges above the in-network allowed amount.	No coverage

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 for the HSA Plan or the Copay Plan with HRA. Out of Area benefits apply to services received from in-network or out-of-network providers.
2. When you use an out-of-network provider, you are responsible for the coinsurance 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).

Continued on next page.

3. The annual deductible does not apply to the copay.
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 **only to the eligible expense for the office visit charge or urgent care clinic visit charge, unless the plan is administered by Centivo.** 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 or urgent care clinic 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 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 ordered, recommended, or prescribed during your office visit or urgent care clinic visit, those charges may be billed separately from the office visit charge or urgent care clinic visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services. You will be responsible for the applicable cost share and annual deductible for services billed separately from the office visit. For plans administered by Centivo, you will only be responsible for the copay for the office visit, and any services billed as part of the office visit.
5. For plans administered by Centivo, if a service requires a referral and you do not get one from your designated PCP, you will be responsible for paying an additional $25 in addition to any copay for office visits. The additional amounts do not count toward your annual deductible or out-of-pocket maximum.

The "Cost-sharing for outpatient office visits or urgent care visits" on the previous page applies to the office visit charge for the following types of outpatient office visit care:

- "Acupuncture" – see page 2-54
- "Autism coverage" – see page 2-56
- "Bariatric services" – see page 2-57
- "Chiropractic care and spinal manipulation" – see page 2-59
- "Convenience care (in retail settings)" – see page 2-60
- "Durable medical equipment, supplies, and prosthetics" – see page 2-63
- "Fertility solutions" – see page 2-68
- "Gender affirming services" – see page 2-70
- "Hearing aids" – see page 2-71
- "Homeopathic and naturopathic services" – see page 2-73
- "Maternity care" – see page 2-77
- "Nutritionists" – see page 2-81
- "Office visit — primary care provider" – see page 2-82
- "Office visit — non-primary care physician or specialist" – see page 2-83
- "Office visit — outpatient mental health or substance use" – see page 2-84
- "Outpatient surgery, diagnostic, and therapeutic services" – see page 2-85
- "Palliative care" – see page 2-86
- "Physician services — inpatient and outpatient facilities" – see page 2-87
- "Psychological and neuropsychological testing" – see page 2-90
- "Therapy (outpatient rehabilitation or habilitative therapy sessions)" – see page 2-94
- "Urgent Care" – see page 2-99

A Primary Care Provider (PCP) is a clinician practicing in pediatrics, internal medicine, obstetrics/gynecology, family practice, or general medicine. Only providers within these areas of practice will be processed using the PCP copay.

For plans administered by Centivo, you may only designate a primary care physician who is a Family Medicine physician, a General Practice physician, Internal Medicine physician, or a Pediatrician. For all plans, except those administered by Centivo for charges billed separately from the office visit charge, see the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for those other billed services. An eye exam for individuals diagnosed with diabetes is covered at coinsurance, no deductible. For Centivio only: Services that are billed as part of the office visit charge will not be charged separate coinsurance, and will be covered by the office visit copay.

See the "Prescription drug benefit" section starting on page 2-112 for coverage information and any pre-service authorization instructions for prescribed medications.

Certain services have visit limits or other exclusions. See the specific medical service description in this chapter for more information. Also review the "Exclusions" section starting on page 2-103.

Cost-sharing for telemedicine visits with Included Health

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area[1] coverage
• **HSA Plan** • **Flex HDHP**	You must receive the telemedicine/virtual visit through Included Health. You pay 20% of eligible covered expenses after you satisfy the annual deductible.	No coverage	You must receive the telemedicine/virtual visit through Included Health. You pay 20% of eligible covered expenses after you satisfy the annual deductible.
• **Copay Plan with HRA** **Note:** You may use available HRA dollars for your portion of eligible covered health expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	You must receive the telemedicine/virtual visit through Included Health. You pay a $10 copay.[2,3] For services billed separately from the Included Health telemedicine/virtual visit charge, you pay the applicable Tier 1 or Tier 2 coinsurance for eligible covered expenses after you satisfy the corresponding annual deductible.	No coverage	You must receive the telemedicine/virtual visit through Included Health. You pay a $10 copay.[2,3] For services billed separately from the Included Health telemedicine/virtual visit charge, you pay the applicable Tier 1 or Tier 2 coinsurance for eligible covered expenses after you satisfy the corresponding annual deductible.
• **Local Copay Plan with HRA** **Note:** You may use available HRA dollars for your portion of eligible covered expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	You must receive the telemedicine/virtual visit through Included Health. You pay a $0 copay.[2,3] For services billed separately from the Included Health telemedicine/virtual visit charge, you pay 10% of eligible covered expenses after you satisfy the annual deductible.	No coverage	No coverage

1. Out of Area means your home ZIP code is designated to be outside of the medical plan claims administrator's network service area for the HSA Plan or the Copay Plan with HSA.
2. The annual 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 **only to the charges for the Included Health 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 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 receive other services or supplies ordered, recommended, or prescribed during the telemedicine/virtual visit, those charges may be billed separately, and eligible expenses for covered health services are subject to the annual deductible and applicable coinsurance or additional copay.

The above cost-sharing applies to the visit charge for a telemedicine/virtual visit when using an Included Health provider. See the "Telemedicine visits with Included Health" section on page 2-93 for more information.

For charges billed separately from the Included Health telemedicine/virtual office visit charge, see the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for those other billed services.

See the "Prescription drug benefit" section starting on page 2-112 for coverage information and any pre-service authorization instructions for prescribed medications.

Cost-sharing for telemedicine/virtual appointments with other providers will be based on the type of services billed by the provider. If the service is not billed by Included Health for a telemedicine visit, the service is not eligible for the copay cost-sharing noted on this page.

Certain services have visit limits or other exclusions. See the specific medical service description in this chapter for more information. Also review the "Exclusions" section starting on page 2-103.

Cost-sharing for other medical care, supplies, and services

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
• **HSA Plan** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the annual deductible.	You pay 50% of eligible covered expenses after you satisfy the annual deductible.[2]	HSA Plan: You pay 20% of eligible covered expenses after you satisfy the annual deductible.[2] Flex HDHP: Out of Area coverage does not apply.
• **Copay Plan with HRA** This plan has a tiered in-network structure, for more information about the tiers, see the "Provider networks — general information" section on page 2-10 and the UnitedHealthcare provider networks "Copay Plan with HRA" section on page 2-11. **Note:** You may use available HRA dollars for your portion of eligible covered health expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	**Tier 1:** • You pay 10% of eligible covered expenses after you satisfy the Tier 1 annual deductible. **Tier 2:** • You pay 30% of eligible covered expenses after you satisfy the Tier 2 annual deductible.	You pay 50% of eligible covered expenses after you satisfy the annual deductible.[2]	You pay 10% of eligible covered expenses after you satisfy the Tier 1 annual deductible.[2]
• **Local Copay Plan with HRA**[3] **Note:** You may use available HRA dollars for your portion of eligible covered health expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	You pay 10% of eligible covered expenses after you satisfy the annual deductible	No coverage	No coverage

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 for the HSA Plan or the Copay Plan with HRA. Out of Area benefits apply to services received from in-network or out-of-network providers.
2. When you use an out-of-network provider, you are responsible for the coinsurance 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).
3. For plans administered by Centivo, if you do not have a referral for the surgeon performing a nonemergency procedure, you will pay an additional $250 for out-patient surgical services, and an additional $500 for inpatient services that will be your responsibility. The additional amounts you pay do not count toward your out-of-pocket maximum.

The above cost-sharing applies to the following types of care that are not billed as office visits:

- "Acupuncture" – see page 2-54
- "Autism coverage" – see page 2-56
- "Bariatric services" – see page 2-57
- "Chiropractic care and spinal manipulation" – see page 2-59
- "Dental care" – see page 2-61
- "Durable medical equipment, supplies, and prosthetics" – see page 2-63
- "Extended skilled nursing care" – see page 2-67
- "Fertility solutions" – see page 2-68
- "Gender affirming services" – see page 2-70
- "Hearing aids" – see page 2-71
- "Home health care" – see page 2-72
- "Homeopathic and naturopathic services" – see page 2-73
- "Hospice care" – see page 2-74
- "Hospital inpatient services" – see page 2-75
- "Maternity care" – see page 2-77
- "Mental health and substance use residential treatment" – see page 2-78
- "Nutritional formulas" – see page 2-80
- "Nutritionists" – see page 2-81

- "Outpatient surgery, diagnostic, and therapeutic services" – see page 2-85
- "Palliative care" – see page 2-86
- "Physician services — inpatient and outpatient facilities" – see page 2-87
- "Psychological and neuropsychological testing" – see page 2-90
- "Reconstructive surgery" (non-elective) – see page 2-91
- "Skilled nursing facility" – see page 2-92
- "Therapy (outpatient rehabilitation or habilitative therapy sessions)" – see page 2-94
- "Transplant services" – see page 2-95
- "Urgent Care" services other than visit charge – see page 2-99

For some of the services above, you may incur a separate office visit charge, see the "Cost-sharing for outpatient office visits or urgent care visits" section starting on page 2-47 for what you will pay for an associated office visit charge.

See the "Prescription drug benefit" section starting on page 2-112 for coverage information and any pre-service authorization instructions for prescribed medications.

Certain services have visit limits or other exclusions. See the specific medical service description in this chapter for more information. Also review the "Exclusions" section starting on page 2-103.

Cost-sharing for eligible preventive care services

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area[1] coverage
• **HSA Plan** • **Flex HDHP**	The medical plan pays 100% of eligible covered expenses.[2]	You pay 50% of eligible covered expenses.[2,3]	HSA Plan: The medical plan pays 100% of eligible covered expenses.[2,3] Flex HDHP: Out of Area coverage does not apply.
• **Copay Plan with HRA** **Note:** You may use available HRA dollars for your portion of eligible covered health expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	The medical plan pays 100% of eligible covered expenses.[2]	You pay 50% of eligible covered expenses.[2,3]	The medical plan pays 100% of eligible covered expenses.[2,3]
• **Local Copay Plan with HRA** **Note:** You may use available HRA dollars for your portion of eligible covered health expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	The medical plan pays 100% of eligible covered expenses.[2]	No coverage	No coverage

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 for the HSA Plan or the Copay Plan with HRA. Out of Area benefits apply to services received from in-network or out-of-network providers.
2. You are not required to satisfy the annual deductible for covered preventive care services. However, for charges billed without a preventive services code, see the "Cost-sharing for outpatient office visits or urgent care visits" section starting on page 2-47 for what you will pay for associated office visit charge and the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for other billed services.
3. When you use an out-of-network provider, you are responsible for the coinsurance 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 above cost-sharing applies to the following types of care when the charges are coded as preventive care services:

- "Preventive care services" – see page 2-88
- "Women's preventive health care services" – see page 2-100

For the following preventive care services, you will pay 20% coinsurance, no deductible, and the plan will pay 80%:

- Glucometer
- Hemoglobin A1C testing
- International normalized ratio (INR) testing
- Low-density Lipoprotein (LDL) testing
- Retinopathy screening

With respect to the high-deductible health plans (HSA Plan and Flex HDHP), 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 Local Copay Plan with HRA may also require a specific diagnosis. UnitedHealthcare covers Hemoglobin A1C testing and LDL testing at 100% with no annual deductible.

See the "Prescription drug benefit" section starting on page 2-112 for coverage information and any pre-service authorization instructions for prescribed medications.

If the charges are not coded as preventive care services, you will pay the applicable office visit copay or annual deductible and coinsurance. See the "Cost-sharing for outpatient office visits or urgent care visits" section starting on page 2-47 and the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for more information.

Certain services have visit limits or other exclusions. See the specific medical service description in this chapter for more information. Also review the "Exclusions" section starting on page 2-103.

Cost-sharing for emergency care services

Plan	What you pay		
	In-network providers	**Out-of-network providers**	**Out of Area[1] coverage**
• **HSA Plan** • **Flex HDHP**	You pay 20% of eligible covered expenses after you satisfy the annual deductible.	You pay 20% of eligible covered expenses after you satisfy the annual deductible.[2]	HSA Plan: You pay 20% of eligible covered expenses after you satisfy the annual deductible. Flex HDHP: Out of Area coverage does not apply.
• **Copay Plan with HRA** **Note:** You may use available HRA dollars for your portion of eligible covered health expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	You pay 10% for eligible covered expenses, after you satisfy the Tier 1 annual deductible, regardless of whether the in-network provider is Tier 1 or Tier 2.	You pay 10% for eligible covered expenses after you satisfy the Tier 1 annual deductible.[2]	You pay 10% for eligible covered expenses, after you satisfy the Tier 1 annual deductible.
• **Local Copay Plan with HRA** **Note:** You may use available HRA dollars for your portion of eligible covered health expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.	You pay a $250 copay for an emergency room visit, copay waived if admitted. For ambulance transport to the nearest hospital and for services billed separately from the ambulance transport charge, you pay 10% of eligible covered expenses after you satisfy the annual deductible.	You pay a$250 copay for an emergency room visit copay waived if admitted. For ambulance transport to the nearest hospital and for services billed separately from the ambulance transport charge, you pay 10% of eligible covered expenses after you satisfy the annual deductible.	No coverage

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 for the HSA Plan or Copay Plan with HRA. Out of Area benefits apply to services received from in-network or out-of-network providers.
2. See the "Surprise billing protections" section on page 2-102 for additional information about billing for emergency services.

The above cost-sharing applies to the following types of care:

- "Ambulance" (emergency and non-emergency transport) – see page 2-55
- "Emergency care" – see page 2-66

Under the Copay Plan with HRA, emergency care includes the charge for emergency ambulance transport, emergency room, attending physicians, radiology, anesthesiology, pathology, and lab work done during the emergency room visit. All other charges are subject to applicable Tier 1 or Tier 2 annual deductible and coinsurance as stated under the "Cost-sharing for other medical care, supplies, and services" on page 2-50.

If you receive emergency services from an out-of-network provider, covered health 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 for emergency services. For more information, see the "Surprise billing protections" section starting on page 2-102.

See the "Prescription drug benefit" section starting on page 2-112 for coverage information and any pre-service authorization instructions for prescribed medications.

Certain services have visit limits or other exclusions. See the specific medical service description in this chapter for more information. Also review the "Exclusions" section starting on page 2-103.

Acupuncture

Acupuncture involves careful and deliberate pricking of the skin or tissues with needles, generally used to treat pain and various other conditions.

Covered	Not covered
Acupuncture services received from a licensed or certified physician, chiropractor, or acupuncturist acting within the scope of that license or certification.	See the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important Information:

Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined. 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.

If UnitedHealthcare or Anthem BCBS is your claims administrator and the acupuncture is administered by a chiropractor, it will count toward the 26-visit limit for chiropractic care.

Ambulance

Professional ambulance services – ground or air

Covered	Not covered
• Emergency ground 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. • Emergency 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. • Nonemergency ground 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). • Nonemergency ground 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.	• 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 ambulance services, except as noted in the previous column. • Transportation services that are not necessary for basic or advanced life support. • Transportation services that are mainly for your convenience. Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for emergency care services" section on page 2-53 for what you will pay for emergency ambulance services.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for nonemergency ambulance services and for any additional services billed beyond the ambulance charge.

Other important information:

If air ambulance services are used and the claims administrator determines that air transport is not covered (for example, because it is not medically necessary or where air transport is directed to a facility other than the facility approved by the claims administrator) no amount will be allowed for air transport, and you will be responsible for any air ambulance charges.

If emergency ambulance services are used and the claims administrator determines that emergency transport is not covered (for example, because it is not medically necessary or where transport is directed to a facility other than the facility approved by the claims administrator) no amount will be allowed for ambulance transport, and you will be responsible for any ambulance charges.

Nonemergency ambulance services are limited as noted above and are subject to pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-40 for more information). In cases where pre-authorization is not obtained for nonemergency ambulance services or where the claims administrator has determined that ground ambulance transport is not covered (for example, because it is not medically necessary) no amount will be allowed for ambulance transport, and you will be responsible for any ambulance charges.

Autism coverage

Applied Behavioral Analysis (ABA) Intensive Behavioral Therapy (IBT) is behavioral therapy focused on primarily building skills and capabilities in communication, social interaction, and learning services for enrolled participants and dependents diagnosed with autism and autism spectrum disorders.

Covered	Not covered
Generally, covered health 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	• 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, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- For the Copay Plan with HRA, the Tier 1 copay or annual deductible and coinsurance apply to eligible covered autism services received from an in-network provider, regardless of whether the provider is in the Tier 1 or Tier 2 network. Services must be billed as an office visit for the copay to apply.

Other important information:

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 2-40 for more information).

It recommended that you call the applicable claims administrator before receiving other services for autism 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.

Bariatric services

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.

Covered	Not covered
In-network gastric bypass or lap band surgery if specific criteria are met.	• 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, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-40 for more information).

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" section starting on page 2-75. For more information on outpatient surgery, see the "Outpatient surgery, diagnostic, and therapeutic services" section starting on page 2-85.

- **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 "Office visit — outpatient mental health or substance use" section starting on page 2-84 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 certain medical services received outside your service area" section on page 2-97 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 is one that 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 the Local Copay Plan with HRA, 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 local network associated with your plan. Also see the "Transportation and lodging for certain medical services received outside your service area" section on page 2-97. **Exception:** Members enrolled in the HSA Plan Out of Area coverage administered by Anthem BCBS are not required to receive services from a Blue Distinction Center and participating provider.

- **Centivo:**

  You must receive services from a qualified bariatric surgeon and facility, as determined by Centivo, in order for services to be covered. Also see the "Transportation and lodging for certain medical services received outside your service area" section on page 2-97.

Chiropractic care and spinal manipulation

Covered	Not covered
• Spinal treatment (including chiropractic and osteopathic manipulative therapy) when provided by a spinal treatment provider in the provider's office. • 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.	• 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, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

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. 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)

A convenience clinic is also known as a retail health clinic. Convenience clinics typically treat minor health issues such as, but not limited to, sore throats and ear and sinus infections.

Covered	Not covered
Convenience care visit	See the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed convenience care office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as a convenience care office visit.

Other important information:

You will be directed to a clinic or hospital if you cannot be treated at a convenience clinic.

A convenience clinic is not an urgent care center. For information on benefits related to urgent care, see the "Urgent Care" section on page 2-99.

Dental care

Covered	Not covered
If pre-service authorization is received, the medical plans cover: • **Hospital-related dental services** Certain hospital services (see the "Covered health services definition" section starting on page 2-43). 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** Treatment received from a physician or dentist for an accidental injury to sound, natural teeth. 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** Treatment of cleft lip and palate for a dependent child under age 18.	• 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 page 2-62 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, see the "Exclusions" section starting on page 2-103.

Covered	Not covered
• **Orthognathic surgery** Orthognathic surgery that meets the claims administrator's medical policy criteria. • **Oral surgery** 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)** - Services for nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, which include removable appliances for TMJ. Covered health 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.	

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important Information:

Pre-service authorization is required. See the "Pre-service authorization requirements" section starting on page 2-40 for more information.

Durable medical equipment, supplies, and prosthetics

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, the items must be custom manufactured or custom fitted to the patient for diagnosed condition

Covered	Not covered
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 • Replacement or repair of any covered items if the items are - Lost - Stolen • Shoe or foot orthotics • Speech devices • Standard hospital bed • Wheelchairs (standard, electric, or custom) when ordered by a physician and medically necessary • Upgraded wheelchairs may be covered. Members must contact their claims administrator before receiving any service, supply, or purchase, to initiate the process; otherwise upgrades to wheelchairs will not be covered. Upgrades are not applicable to other DME services and supplies. • Wigs up to $500 per calendar year as deemed medically necessary by the claims administrator Covered supplies include the following when the claims administrator's medical criteria are met: • 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	• 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, including elastic stockings, ace bandages, and gauze, except as noted in the "Covered" column on this page • 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 2-61 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 • 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

Covered	Not covered
Covered prosthetics include the following when the claims administrator's medical criteria are met: • A single purchase, including repairs, of a prosthetic device that replaces a limb or body part, including artificial limbs and artificial eyes • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998	• Vehicle, car, or van modifications, including but not limited to hand brakes, hydraulic lifts, and car carriers • 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" section starting on page 2-71 for more information) • Charges for purchase or replacement of eyeglasses, contact lenses, or other optical devices or professional services, including charges 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 2-112 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 2-61 Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- For the Copay Plan with HRA, the Tier 1 annual deductible and coinsurance apply to eligible covered durable medical equipment and prosthetics obtained from an in-network provider, regardless of whether the provider is in the Tier 1 or Tier 2 network.

Other important Information:

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 2-40 for more information. 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 2-100.

Durable medical equipment, supplies, and prosthetics must be obtained from, or repaired by, approved vendors.

If more than one piece of durable medical equipment or prosthetic device can meet your functional needs, benefits are available only for the most cost-effective piece of equipment or device.

Benefits are provided for the replacement of durable medical equipment or a prosthetic device. 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).

Benefits are provided for unlimited repair of durable medical equipment, or a prosthetic device.

However, if the durable medical equipment or prosthetic device is worn out or no longer functional and repair is not possible or would equal or exceed the cost of replacement, the claims administrator may, at their discretion, approve replacement of the equipment sooner than three years. An assessment by a rehabilitation equipment specialist or vendor must be done to validate that the item is no longer functional and cannot be repaired (or that the cost to repair would equal or exceed the cost to replace), and provide the cost of repairs (if applicable) and the cost of replacement to the claims administrator for a determination.

Emergency care

Services needed 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.

Covered	Not covered
Emergency care services needed for accidental injury and other medical emergencies treated in an emergency room if in the judgement of a reasonable person, immediate care and treatment are required, generally within 24 hours of onset to avoid jeopardy to life or health.	• Nonemergency use of the emergency room, as determined by the claims administrator. 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, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for emergency care services" section on page 2-53 for what you will pay.

Other important Information:

For ambulance or air ambulance services, see the "Ambulance" section starting on page 2-55.

For services received at an urgent care center see the "Urgent Care" section on page 2-99.

For life-threatening medical emergency or serious accidental injury coverage is provided for hospital emergency room or freestanding emergency facility care, including a medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition, and within the capabilities of the staff and facilities available at the hospital, such further medical or mental health examination and treatment as are required to stabilize the patient. Emergency care does not require any prior authorization from the plan. Emergency care may also include necessary services, including observation services, provided as part of the emergency visit regardless of the department in which the services are provided.

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.

Covered	Not covered
With pre-service authorization before receiving services, the medical plans cover extended skilled nursing care. 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. 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.	• 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, unless determined to be medically necessary by the claims administrator. • Prescription drugs that do not require administration by a health care professional. See the "Prescription drug benefit" section starting on page 2-112 for coverage information. Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- See the "Prescription drug benefit" section starting on page 2-112 for coverage information and any pre-service authorization instructions for prescribed medications.

Other important information:

Pre-service authorization is required before receiving extended skilled nursing services. See the "Pre-service authorization requirements" section starting on page 2-40 for more information.

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). 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.

For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home, see the "Prescription drug benefit" section starting on page 2-112 for coverage information and preservice authorization requirements and instructions.

Fertility solutions

Expenses related to in-network infertility and fertility services and treatment

Covered	Not covered
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.	• 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 when a diagnosis of cancer is not present • Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation) Also, see the "Exclusions" section starting on page 2-103.

Covered	Not covered
• 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	

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

Pre-service authorization is required for all fertility solutions services and treatments (see the "Pre-service authorization requirements" section starting on page 2-40 for more information). Covered employees and dependents must use a designated network of providers for certain fertility solutions services. A provider is not necessarily considered a designated provider just because it is an in-network provider. Contact your claims administrator for more information before starting to receive any services or treatments noted in 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 under the HSA Plan and the Copay Plan with HRA.

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 2-112 for more information on prescription drugs, coverage, and pre-service authorization requirements.

See the "Transportation and lodging for certain medical services received outside your service area" section on page 2-97 for information about covered travel expenses related to infertility and fertility services and treatment.

Fertility solutions benefits are in addition to/separate from those covered in the "Women's preventive health care services" section starting on page 2-100.

Gender affirming services

For gender affirming services, 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:** Not all WPATH recommended services are covered under this Plan.

Covered	Not covered
Generally, covered expenses include: • Outpatient office visits • Pre- and postsurgical hormone therapy covered under the pharmacy benefit • Gender affirming facial surgery, including but not limited to facial bone reduction, face "lift," facial hair removal, and certain facial plastic procedures • Hair removal for skin grafting related to genital reconstruction • Hair transplant coverage for gender affirming care • 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 preservice authorization • Voice modification surgery • Voice therapy	• Cosmetic surgery (except as previously noted for gender affirming services) • Charges for services or supplies that are not based on the guidelines set forth by the WPATH as determined by the claims administrator • Cryopreservation of fertilized embryos • Sperm preservation in advance of hormone treatment or gender affirming surgery Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

Inpatient hospital services require pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-40 for more information). **However, it is strongly recommended that you call the applicable claims administrator before receiving any 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.

Gender affirming surgery benefits are limited to one reassignment per covered person per lifetime.

See the "Transportation and lodging for certain medical services received outside your service area" section on page 2-97 for information about covered travel expenses related to gender affirming services.

Hearing aids

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.

Covered	Not covered
Generally, covered expenses include: • A hearing aid that is prescribed by a physician or appropriate provider or clinician as determined by the claims administrator • Associated fitting and testing for the covered hearing aid • External cochlear devices and systems • Surgery to place a cochlear implant (inpatient or outpatient procedure) • Post cochlear implant aural therapy	• 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, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

The medical plans cover up to one hearing aid or set of hearing aids every three plan years.

Inpatient hospital services require pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-40 for more information). **However, it is strongly recommended that you call the applicable claims administrator before receiving any services** to ensure that the services you seek are covered under the plan.

Home health care

Health services for treatment of a disease or injury in the patient's home instead of a hospital or skilled nursing facility. 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. Charges for home health care must be made by a home health care agency.

Covered	Not covered
With pre-service authorization before receiving services, the following types of home health care 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: • 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 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.	• 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 help getting in and out of bed or transferring from a bed to a chair, dressing, feeding/eating, bathing, walking, taking medication, as well as ostomy care, hygiene, or incontinence care, and checking of routine vital signs. • Private-duty nursing, unless determined to be medically necessary by the claims administrator • 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 • Services provided by a family member or a person living in your home • 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. See the "Prescription drug benefit" section starting on page 2-112 for coverage information. Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- For the Copay Plan with HRA, the Tier 1 annual deductible and coinsurance apply to eligible covered home health care received from an in-network provider, regardless of whether the provider is in the Tier 1 or Tier 2 network.

Other important information:

Home health care services require pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-40 for more information).

One visit is equal to four consecutive hours in a 24-hour period.

Covered health services are limited to 100 visits per plan year by a home health care professional. The 100-visit maximum, combined with extended skilled nursing care, is for combined in-network and out-of-network services. 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.

For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home; see the "Prescription drug benefit" section starting on page 2-112 for coverage information and pre-service authorization requirements and instructions for prescribed medications.

Homeopathic and naturopathic services

Covered	Not covered
• Homeopathic and naturopathic office visits with a state-licensed homeopathic or naturopathic provider	• Charges for services received from a non-licensed naturopathic or homeopathic provider or a provider licensed outside of the state where services are rendered • Services not considered medically necessary by your claims administrator Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

Homeopathic and naturopathic providers are not licensed in all states; if you receive services from an unlicensed provider, you are responsible for all charges.

Hospice care

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 anticipated life expectancy of less than six months.

Covered	Not covered
With pre-service authorization before receiving services, the following types of types of hospice care prescribed by a physician and provided by a licensed hospice agency: • Symptom management • Inpatient care only • 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	• 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, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for hospice services
- For the Copay Plan with HRA, the Tier 1 annual deductible and coinsurance apply to eligible covered hospice care received from an in-network provider, regardless of whether the provider is in the Tier 1 or Tier 2 network.

Other important information:

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-40 for more information).

Hospital inpatient services

Inpatient hospital admissions, inpatient treatment, or other inpatient medical facility admissions, including residential treatment, structured outpatient care, intensive outpatient therapy, and partial hospitalizations.

Covered	Not covered
With pre-service authorization, the following types of inpatient hospital services: • Semiprivate room and board • Newborn nursery facilities **Note:** For newborn care, you must add your child to your medical coverage at Wells Fargo through Workday within 60 days of the date of birth. See the "Qualified Events" section in "Chapter 1: Enrollment, Eligibility, and More," for more information. • Physician and other professional medical and surgical services during an inpatient hospital stay • General nursing care • Prescription drugs or other medications administered during treatment • Anesthesia • Laboratory and diagnostic imaging services • Other diagnostic or treatment-related hospital services • Use of operating rooms • 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 • Intensive care and intensive cardiac care facilities • Miscellaneous medically appropriate hospital services and supplies, except as noted under the "Not covered" section in the next column • Residential treatment or structured outpatient care (which are considered forms of inpatient care) • 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	• Private room charges when facility has a semiprivate room available • 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, unless determined to be medically necessary by the claims administrator • Telephone toll billings for Christian Science services • Out-of-network inpatient services for spine (back) and joint (knees and hips) procedures • 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 Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- For the Copay Plan with HRA, the Tier 1 annual deductible and coinsurance apply to eligible covered mental health or substance use inpatient hospital services received from an in-network provider, including residential treatment or structured outpatient care which are considered forms of inpatient hospital services, regardless of whether the provider is in the Tier 1 or Tier 2 network.

Other important information:

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-40 for more information).

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, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

For Anthem BCBS only:

- 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.

For 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 may be reduced.
- Where assistant surgeon services are appropriate, the allowed amount will be reduced 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.

For eligible spine (back) and joint (knees and hips) procedures:

- **No coverage for services received from out-of-network providers.**
- Contact you claims administrator for information about completing Orthopedic Treatment Decision Support ("Treatment Decision Support" or "TDS") before receiving surgical services
- The patient may receive a phone call from a nurse to discuss and share important health care information related to the spine (back) and joint (knees and hips) inpatient surgery.
- If you use a designated facility for inpatient surgery, complete the TDS, and receive approved pre-service authorization, 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.
- For **Anthem BCBS only**: If you are enrolled in the Local Copay Plan with HRA, Blue Distinction Centers provisions do not apply, but you do need to receive services from an Anthem Blue High Performance Network facility. You must also complete TDS, and have an approved pre-service authorization for the treatment for the plan to pay 100% of eligible expenses after you satisfy your deductible.

For services provided on an outpatient basis, see the "Outpatient surgery, diagnostic, and therapeutic services" section on page 2-85.

Maternity care

Services for prenatal care, postnatal care, delivery, and any related complications.

Covered	Not covered
• Initial office visit to diagnose pregnancy • 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. • Lab work • Ultrasound • Inpatient hospital services • Certified 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. **Note:** For Anthem BCBS, certified out-of network midwives are covered at applicable out-of-network cost share.	• Adoption • Childbirth classes • Preparation to be a surrogate or gestational carrier including any donor, insemination, implantation, or transfer processes Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit, including a global bill, and other services billed separately such as but not limited to labs, ultrasounds, services provided by a specialist, and hospital and separate physician charges.
  - 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.

Other important information:

Some prenatal and postnatal care is considered eligible preventive care. See the "Preventive care services" section starting on page 2-88 and "Women's preventive health care services" section on page 2-100 for more information about coverage of these services.

Minimum hospital stays: The medical plans will pay benefits for the covered mother and the newborn (expenses for the newborn are covered only if you add your child to your medical coverage at Wells Fargo through Workday within 60 days of the date of birth. See the "Qualified Events" section in "Chapter 1: Enrollment, Eligibility, and More," for more information) 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.

Mental health and substance use residential treatment

Residential treatment is considered inpatient hospital care. 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.

Covered	Not covered
• If pre-service authorization is received, the medical plans cover mental health and substance use licensed residential treatment services that are provided in a facility or a freestanding residential treatment center that provides overnight mental health services or substance use treatment for individuals who do not require acute inpatient care but who do need 24-hour medical supervision. **Note:** The residential treatment facility must meet the criteria noted below under "Other important information" • For more information about inpatient hospital coverage, see "Hospital inpatient services" on page 2-75. • See "Emergency care" on page 2-66 for the definition of Emergency care.	• 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, recreational or lifestyle program (and the like), 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, or wilderness or outdoor camps and programs, even if psychotherapy is included. Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for a residential treatment stay.
- For the Copay Plan with HRA, the Tier 1 annual deductible and coinsurance apply to eligible covered mental health or substance use residential treatment at an in-network facility, regardless of whether the facility is in the Tier 1 or Tier 2 network.

Other important information:

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-40 for more information).

A residential treatment facility is a facility that provides a program of effective mental health or substance use services and treatment 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

For services 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.

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.

For information on outpatient mental health and substance use office visits, see the "Office visit — outpatient mental health or substance use" section on page 2-84.

Nutritional formulas

Covered	Not covered
• Nutritional formulas 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 • Nutritional formulas used as the sole source of nutrition by enteral feedings, as deemed medically appropriate and necessary based on the claims administrator's medical policy • Total parenteral nutrition and intravenous (TPN/IV) therapy, equipment, supplies, and drugs in connection with IV therapy.	• Enteral feedings and nutritional formulas, including infant formula (except as noted as covered) • 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, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit

Other important information:

IV line care kits are covered as durable medical equipment. See the "Durable medical equipment, supplies, and prosthetics" section starting on page 2-63 for more information.

Nutritionists

Nutritional counseling provided in a physician's office by an appropriately licensed nutritionist or health care professional when education is required for a disease (medical or behavioral health related) 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.

Covered	Not covered
Nutritional counseling for the following medical conditions: • Anorexia • Bulimia • Congestive heart failure • Coronary artery disease • Diabetes • Gout • High cholesterol • Obesity • Phenylketonuria (PKU) • Renal failure • Severe obstructive airway disease	• Nutritional counseling for either individuals or groups (except as stated as covered) • Weight loss programs unless sponsored by Wells Fargo • Health clubs • Spa programs Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

NA

Office visit — primary care provider

An office visit with a primary care physician (defined below) for diagnosis or treatment of an injury or illness. This includes an in-person office visit or a virtual office visit (other than an Included Health telemedicine virtual visit — for more information see the "Telemedicine visits with Included Health" section on page 2-93)

Covered	Not covered
• Charges billed as an office visit with a primary care provider • Outpatient office visits (including couples counseling) for professional mental health and substance use 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.	• Services from a physician or provider who is not listed as an eligible primary care physician 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" section starting on page 2-75. • Prescription drugs that do not require administration by a health care professional Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

A Primary Care Provider (PCP) is a clinician practicing in pediatrics, internal medicine, obstetrics/gynecology, family practice, or general medicine. Only providers within these areas of practice will be processed using the PCP copay.

For plans administered by Centivo, you may only designate a primary care physician who is a Family Medicine physician, a General Practice physician, Internal Medicine physician, or a Pediatrician. 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, unless your plan is administered by Centivo. Such services may include but are not limited to diagnostic services (for example, lab work, x-rays, MRI, pathology, or psychological or neuropsychological testing), surgical services, or services performed by a specialist brought into 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.

Residential treatment, structured outpatient care, intensive outpatient therapy, and partial hospitalizations are considered inpatient care (see the "Hospital inpatient services" section starting on page 2-75).

Applied behavioral analysis (ABA) services are considered under the "Autism coverage" section starting on page 2-56.

For prescription drugs that require administration under the direct supervision of a health care professional and cannot be administered in the home, see the "Prescription drug benefit" section starting on page 2-112 for coverage information, pre-service authorization requirements and instructions, and information about how to order and ship specialty medications from the Accredo Specialty Pharmacy to the physician's office.

For obstetrical and gynecological office visits related to pregnancy or maternity care, see the "Maternity care" section starting on page 2-77.

Office visit — non-primary care physician or specialist

An office visit with a non-primary care physician or specialist for diagnosis or treatment of an injury or illness. This includes an in-person visit or a virtual visit (other than an Included Health telemedicine virtual visit — for more information see the "Telemedicine visits with Included Health" section on page 2-93)

Covered	Not covered
• Charges billed as an office visit with a specialist or other physician who is who is not defined as an eligible primary care physician (see the "Office visit — primary care provider" section starting on page 2-82 for a listing of the types of providers who are considered eligible primary care physicians).	• Services of a Christian Science practitioner or a Christian Science nurse, except as listed in the "Hospital inpatient services" section starting on page 2-75. • Prescription drugs that do not require administration by a health care professional Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- A Primary Care Physician (PCP) is a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. Only these providers will be processed using PCP copay.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

Some services may require pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-40).

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. Such services may include but are not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by a specialist brought into 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.

For prescription drugs that require administration under the direct supervision of a health care professional and cannot be administered in the home, see the "Prescription drug benefit" section starting on page 2-112 for coverage information, pre-service authorization requirements and instructions, and information about how to order and ship specialty medications from the Accredo Specialty Pharmacy to the physician's office.

For obstetrical and gynecological office visits related to pregnancy or maternity care, see the "Maternity care" section starting on page 2-77.

Mental health and substance use providers are considered primary care providers; see the "Office visit — primary care provider" section on page 2-82.

Office visit — outpatient mental health or substance use

An office visit with a non-primary care physician or specialist for mental health or substance use diagnosis or treatment. This includes an in-person visit or a virtual visit (other than an Included Health telemedicine virtual visit – for more information see the "Telemedicine visits with Included Health" section on page 2-93)

Covered	Not covered
• Professional mental health and substance use 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. • Couple's counseling • Family counseling	See the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- For the Copay Plan with HRA, the Tier 1 copay or annual deductible and coinsurance applies to eligible covered health services received from an in-network licensed mental health or substance use provider, regardless of whether the provider is in the Tier 1 or Tier 2 network. Services must be billed as an office visit for the copay to apply.
- For the Local Copay Plan with HRA administered by Centivo, you can access any licensed mental health or substance use provider, regardless of whether the provider is in the network. If the provider will not submit a claim on your behalf, you may submit a claim form for direct reimbursement from Centivo. Reimbursement for out-of-network services will be based on in-network allowed amounts, and your provider can bill you for the difference between the billed charges and the allowed amount.

Other important information:

Covered health services and supplies are based on the coverage criteria or medical policy of the claims administrator. Contact the claims administrator for information.

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. Such services may include but are not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by a specialist brought into 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.

Coverage for psychological or neuropsychological testing services are described under the "Psychological and neuropsychological testing" section on page 2-90.

For information on residential treatment, structured outpatient care, intensive outpatient therapy, and partial hospitalizations see the "Mental health and substance use residential treatment" section starting on page 2-78.

For information on applied behavioral analysis (ABA), see the "Autism coverage" section starting on page 2-56.

For prescription drugs that require administration under the direct supervision of a health care professional and cannot be administered in the home, see the "Prescription drug benefit" section starting on page 2-112 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.

Methadone maintenance includes coverage for pain management for medical services conditions and methadone treatment for opioid addition (MH/SUD) conditions.

Outpatient surgery, diagnostic, and therapeutic services

Services received on an outpatient basis in a physician's office, at a clinic, and at a hospital or alternate facility

Covered	Not covered
• Diabetes outpatient self-management training and education, including medical nutrition therapy. • Scheduled outpatient surgery, anesthesia, and related services. • Outpatient 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. • Outpatient radiation and chemotherapy • Outpatient kidney dialysis (both hemodialysis and peritoneal dialysis) • Lab work • X-rays • Medical education services: 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.	• 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. • 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 Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
  - Services coded by your provider as received in an outpatient facility will be subject to the annual deductible and coinsurance (not the office visit copay or coinsurance).
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- For the Copay Plan with HRA, the Tier 1 copay will apply to eligible covered lab work completed in a free-standing in-network lab facility, regardless of whether the free-standing lab facility is in the Tier 1 or Tier 2 network.

Other important information:

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 may be reduced.

Where assistant surgeon services are appropriate, the allowed amount for the assistant surgeon will be reduced 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 or 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.

For prescription drugs that require administration under the direct supervision of a health care professional and cannot be administered in the home, see the "Prescription drug benefit" section starting on page 2-112 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.

For obstetrical and gynecological office visits related to pregnancy or maternity care, see the "Maternity care" section starting on page 2-77.

Some services may require pre-service authorization (see the "Pre-service authorization requirements" section starting on page 2-40) such as but not limited to:

- 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

For services provided on an inpatient basis, see the "Hospital inpatient services" section on page 2-75.

Palliative care

Palliative care is focused on providing relief from the symptoms and stress of serious illness, such as but not limited to cancer, COPD, kidney disease, congestive heart failure, or ALS. The goal is to improve the quality of life for the patient who has a life expectancy of two years or less.

Covered	Not covered
• 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	See the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

NA

Physician services — inpatient and outpatient facilities

These are services provided by a physician that are not billed as an office visit charge.

Covered	Not covered

• Physician services:
  - 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
• Anesthesia administered by a provider other than the operating, delivering, or assisting provider
• Treatment of eye disease
• Diabetes outpatient self-management training and education, including medical nutrition therapy
	• 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
	• Separate charges for pre- and postoperative care for surgery
	• 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
	Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
  - Services coded by your provider as received in an outpatient facility will be subject to the outpatient facility coinsurance (not the office visit copay or coinsurance).
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- For prescription drugs that require administration under the direct supervision of a health care professional and cannot be administered in the home, see the "Prescription drug benefit" section starting on page 2-112 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.

Other important information:

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 may be reduced.

Where assistant surgeon services are appropriate, the allowed amount will be reduced 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.

Preventive care services

Covered	Not covered
• **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 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 • **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 - An HDHP can provide the following additional services without a deductible: ◦ OTC contraceptives (including emergency contraceptives) with or without a prescription ◦ Male condoms	• 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, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for eligible preventive care services" section on page 2-52 for what you will pay for preventive care.
- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 and the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as preventive care.
- For the following preventive care services, you will pay the applicable coinsurance with 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 (HSA Plan and Flex HDHP), 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 Local Copay Plan with HRA may also require a specific diagnosis. UnitedHealthcare covers Hemoglobin A1C testing and LDL testing at 100% with no deductible.

Other important information:

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. 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 annual 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" section on page 2-4). Also, see the "Women's preventive health care services" section starting on page 2-100 for more information on women's preventive health care services.

Psychological and neuropsychological testing

Covered	Not covered
• Psychological and neuropsychological testing when conducted for the purpose of diagnosing a mental disorder 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, or in connection with treatment of such a mental disorder.	• 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 see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
  - Services coded by your provider as received in an outpatient facility will be subject to the outpatient facility coinsurance (not the office visit copay or coinsurance).
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- For the Copay Plan with HRA, the Tier 1 copay or annual deductible and coinsurance applies to eligible covered psychological or neuropsychological testing received from an in-network licensed mental health or substance use provider, regardless of whether the provider is in the Tier 1 or Tier 2 network. Services must be billed as an office visit for the copay to apply.

Other important information:

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 2-40 for the contact information.

Reconstructive surgery

Covered	Not covered
With pre-service authorization: • 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 • Penile prosthesis when deemed medically necessary as defined by the claims administrator. • 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 and one of following is also met: - After significant weight loss unrelated to bariatric surgery, there must be documentation that a stable weight has been maintained for six months. - After significant weight loss following bariatric surgery, there must be documentation that a stable weight has been maintained for six months. This often occurs 12 to 18 months after surgery. Without pre-service authorization: • 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 asymmetrical appearance - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.	• Cosmetic procedures, including but not limited to surgery; pharmacological regimens; nutritional procedures or treatments; scar or tattoo removal or revisions 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 2-61 • Treatment of benign gynecomastia (abnormal breast enlargement in males) Also see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for a billed office visit.
  - Services coded by your provider as received in an outpatient facility will be subject to the outpatient facility coinsurance (not the office visit copay or coinsurance).
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

Pre-service authorization is required for most procedures (see the "Pre-service authorization requirements" section starting on page 2-40 for more information).

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 reduced.

Where assistant surgeon services are appropriate, the claims administrator 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.

Skilled nursing facility

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

Covered	Not covered
With pre-service authorization for inpatient stay in a skilled nursing facility or acute inpatient rehabilitation facility when skilled nursing, rehabilitation services, or both, are needed on a daily basis: • Room and board in a semiprivate room (a room with two or more beds) • Services and supplies received during the inpatient stay	• Services are required intermittently (such as physical therapy three times a week) • 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 • 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, unless determined to be medically necessary by the claims administrator. Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-40 for more information).

Benefits are limited to 100 days per plan year for skilled nursing, in-network and out-of-network services combined. 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. 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 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.

Telemedicine visits with Included Health

Covered	Not covered
• Telemedicine/virtual visits, online or by phone with Included Health providers.	See the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for telemedicine visits with Included Health" section on page 2-49 for what you will pay for the telemedicine/virtual office visit with Included Health.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay if you receive additional services and supplies, even if advised by the Included Health provider during your telemedicine/virtual visit. 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.

Other important information:

Included Health provides medical and behavioral telemedicine virtual visits.

- Medical telemedicine virtual visits offer an integrated, on-demand visit with an urgent care medical staff.
- Behavioral telemedicine virtual visits offer therapy and psychiatry clinicians for behavioral health needs.

Contact Include Health for telemedicine virtual visits.

- Visit www.includedhealth.com/wf
- Call 1-833-200-7683
- Use the Included Health app, which can help you find Included Health telemedicine providers

Note: If you have a virtual visit with any other provider, it is not covered under this benefit. See the "Office visit — primary care provider" section on page 2-82 and the "Office visit — non-primary care physician or specialist" section on page 2-83 for more information.

Therapy (outpatient rehabilitation or habilitative therapy sessions)

(physical therapy, occupational therapy, speech therapy, pulmonary therapy, cardiac therapy, and vision therapy)

Covered	Not covered
• The following rehabilitation services performed by a licensed therapy provider, under the direction of a physician, to restore previously attained function lost due to injury or illness when rehabilitation services are expected to result in significant physical improvement in your condition within two months of the start of treatment. - Physical therapy - Occupational therapy - Speech therapy - Pulmonary rehabilitation therapy - Cardiac rehabilitation therapy • The following habilitative services performed by a licensed therapy provider, under the direction of a physician 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: - Physical therapy - Occupational therapy - Speech therapy • Vision therapy (including lenses, prisms, filters, occlusion, eye exercises, and orthoptics that are used for eye movement and fixation training) to correct or improve specific visual dysfunctions, such as amblyopia, strabismus, and disorders of accommodation and convergence. - 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.	• 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 see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for an office visit charge.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.
- For the Copay Plan with HRA, the Tier 1 copay or annual deductible and coinsurance applies to eligible covered physical therapy, occupational therapy, and speech therapy received from an in-network provider, regardless of whether the provider is in the Tier 1 or Tier 2 network. Services must be billed as an office visit for the copay to apply.

Other important information:

Services may be subject to pre-service authorization requirements (see the "Pre-service authorization requirements" section starting on page 2-40 for more information) and/or assessed for medical necessity based on the claims administrator's medical policy and review guidelines.

Vision therapy is limited to 20 visits combined for in-network and out-of-network services.

Transplant services

Covered	Not covered
When ordered by a physician and with pre-service authorization: • Any of the following types of qualified organ or tissue transplants as determined by the claims administrator's medical policies: - 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 a transplant procedure listed above include: - Pretransplant evaluation - Donor search ◦ **Note:** The donor search for bone marrow and stem cells from a donor who is not biologically related to the patient is only covered when the search and transplant procedures are arranged by a designated facility. - Organ acquisition and procurement ◦ 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. - Hospital and physician fees - Transplant procedures - Follow-up care for a period up to one year after the transplant	• 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 • Transportation and lodging expenses when you are not using a designated facility • 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 Also, see the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for an office visit charge.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an office visit.

Other important information:

Pre-service authorization is required (see the "Pre-service authorization requirements" section starting on page 2-40 for more information).

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

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.

If a qualified procedure is a covered health service and performed at a designated facility, transportation, and lodging provisions may apply. See the "Transportation and lodging for certain medical services received outside your service area" section on page 2-97 for information about covered travel expenses related to transplant surgery.

Transportation and lodging for certain medical services received outside your service area

Covered	Not covered
If the coverage criteria and provider and travel requirements are met as stated under "Other important information below," transportation and lodging benefits may be available for: • Transportation expenses for the patient and one companion who is traveling on the same days to or from the required provider for the purposes of a medical or behavioral health-related evaluation, approved surgical procedure, necessary post-discharge follow-up, or to obtain legal prescriptions. • Transportation includes: - Economy class air, train & bus fares (air travel expenses are only eligible if you reside more than 300 miles from the required provider when such services are not available closer to your place of residence) - Economy car rental, including mileage if charged by rental agreement - Parking (excluding valet services) - Tolls - Mileage for personal car up to IRS limits • Lodging expenses for the patient and one companion The claims administrator's standard allowances and internal policies and procedures apply.	• Services for or related to bone marrow and peripheral stem cell support procedures such as but not limited to chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood-producing organs), supplies, drugs, and aftercare that are considered investigative or not medically necessary as determined by the applicable claims administrator • Living donor organ or tissue transplants unless otherwise specified in this SPD • Transportation and lodging expenses not coordinated by the applicable claims administrator • Transportation and lodging expenses when you are not using a designated facility or qualified provider as determined 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 Also see the "Exclusions" section starting on page 2-103.

Cost-sharing:
Reimbursement provisions are stated above. Reimbursement is not guaranteed.

Other important information:
When you are required to travel to obtain certain covered health services, you may be eligible for reimbursement of transportation and lodging expenses up to IRS limits. Services must be legal in the state provided and you must:

- Meet the claims administrator's coverage criteria for those services.
- Receive the covered health services from a licensed provider acting within the scope of their license. In some cases, you are required to use a specified provider. For more information see the applicable claims administrator section below.
- Reside more than 50 miles from the required provider when such services are not available closer to your place of residence.
- The claims administrator may be able to assist you with locating the closest available in network provider and in making transportation and lodging arrangements. Contact your claims administrator directly. You will need to save your receipts for travel and/or lodging expenses to submit with your claim forms following your services.

Anthem BCBS
If you are enrolled in the HSA Plan or the Flex HDHP, and Anthem BCBS is your claims administrator, you are required to use:

- A Blue Distinction Center of Excellence or qualified provider, as determined by Anthem BCBS, for bariatric surgery; inpatient lumbar spine, knee, or hip surgery; fertility or infertility services; or transplant surgery
- A designated qualified provider as determined by the Anthem BCBS for gender affirming services
- The closest available in-network provider able to legally perform required medical services or legally dispense prescription drugs for covered health services

If you are enrolled in the Local Copay Plan with HRA, you are required to receive bariatric surgery; inpatient lumbar spine, knee, or hip surgery; transplant surgery; gender affirming treatment or infertility treatment at a Blue High Performance Network or a qualified provider, as determined by claims administrator.

Centivo

If you are enrolled in the Local Copay Plan with HRA, and Centivo is your claims administrator, you are required to use:

- A qualified provider as determined by Centivo for bariatric services, cancer treatment, congenital heart disease (CDH)

treatment, fertility or infertility services and treatment, gender affirming services, spine (back) and joint (knee or hip) surgery, or transplant surgery

- The closest available in-network provider able to legally perform required medical services or legally dispense prescription drugs for covered health services

For more information about the covered medical services, see the applicable section in this chapter of the *Benefits Book* or call Centivo.

UnitedHealthcare

If you are enrolled in the HSA Plan, the Copay Plan with HRA, the Local Copay Plan with HRA, or the Flex HDHP and UnitedHealthcare is your claims administrator, you are required to use:

- A designated provider for bariatric services, cancer treatment, congenital heart disease (CDH) treatment, fertility or infertility services and treatment, spine (back) and joint (knee or hip) surgery, or transplant surgery
- A qualified provider as determined by the UnitedHealthcare for gender affirming services
- The closest available in-network provider able to legally perform required medical services or legally dispense prescription drugs for covered health services

For more information about the covered medical services, see the applicable section in this chapter of the *Benefits Book* or call UnitedHealthcare.

Urgent Care

Covered	Not covered
• Urgent care clinic visit	See the "Exclusions" section starting on page 2-103.

Cost-sharing:

- See the "Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 for what you will pay for an urgent care office visit charge.
- See the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as an urgent care office visit.
- For the Copay Plan with HRA, the Tier 1 copay or annual deductible and coinsurance applies to eligible covered urgent care received from an in-network provider, regardless of whether the provider is in the Tier 1 or Tier 2 network. Services must be billed as an urgent care office visit for the copay to apply.

Other important information:

NA

Women's preventive health care services

Covered	Not covered
• Annual well-woman preventive care visit for an adult woman to obtain recommended preventive services that are age and developmentally appropriate • Breast-milk storage bags as well as replacement supplies for electric pumps including standard power adapter, tubing adapters, tubing, locking rings, bottles specific to breast pump operation, caps for bottles that are specific to the breast pump, valves, filters, and breast shield and/or splash protector for use with breast pumps • 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 2-112) • 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 HSA Plan Out of Area coverage and Copay Plan with HRA Out of Area coverage, you are not required to use an in-network hospital, physician, or durable medical equipment (DME) supplier) • 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	• Services not listed as covered • 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 in the previous column) - Items purchased from a retail store Also see the "Exclusions" section starting on page 2-103.

Cost-sharing:

For in-network services, you do not need to satisfy the annual deductible. If you use out-of-network providers while enrolled in the HSA Plan, Flex HDHP, or Copay Plan with HRA, eligible preventive care services are not subject to the out-of-network annual deductible, you pay 50% of the eligible covered expense.

- See the "Cost-sharing for eligible preventive care services" section on page 2-52 for what you will pay for preventive care.
- See the"Cost-sharing for outpatient office visits or urgent care visits" section on page 2-47 and the "Cost-sharing for other medical care, supplies, and services" section on page 2-50 for what you will pay for services that are not billed as preventive care.
- For the following preventive care services, you will pay 20% coinsurance no deductible, and the plan will pay 80%:
  - Glucometer
  - Hemoglobin A1C testing
  - International normalized ratio (INR) testing
  - Low-density Lipoprotein (LDL) testing
  - Retinopathy screening

  With respect to the high-deductible health plans (HSA Plan and Flex HDHP), 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 Local Copay Plan with HRA may also require a specific diagnosis. UnitedHealthcare covers Hemoglobin A1C testing and LDL testing at 100% with no deductible.

Other important information:

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.

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 annual 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 received 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 (state restrictions apply)
- Over-the-counter items

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" section on page 2-4). Also, see the "Preventive care services" section starting on page 2-88 for information on other preventive health care services.

Surprise billing protections

Surprise billing is an unexpected balance bill for medical services. This might happen when you can't control who is involved in your medical care, like when you have an emergency or when you schedule a visit at an in-network facility, but the in-network facility uses an out-of-network provider for some of the services you receive.

New federal rules apply to prevent you from being balance billed for the following services:

- Emergency services (as defined below) when provided by an out-of-network provider.
- Air ambulance (as defined below) when provided by an out-of-network provider.
- Non-emergency services when provided by an out-of-network provider at certain in-network facilities (i.e., a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified by the Secretary of HHS) for the following types of services:
  - Ancillary services (as defined below);
  - Non-ancillary services, if the out-of-network provider has not given proper notice and you have not given proper consent.

These balance billing protections apply to covered services received on or after January 1, 2022.

For the services above, the most those providers may bill you is your plan's in-network cost-sharing amount (deductible and copay or coinsurance percentage) that is based on the allowed amount for such services. The allowed amount for determining your cost share is typically the lesser of the billed charge or the qualifying payment amount. The qualifying payment amount will be determined by the claims administrator in accordance with federal law. Your cost-sharing amount for these services will be applied to your in-network deductible and out-of-pocket maximum.

The claims administrator will determine, or will work with the out-of-network provider or facility to agree upon, the allowed amount for calculating payments due to the out-of-network provider or facility, as applicable. This amount may be different than the allowed amount used to calculate your cost share.

If you have been balance-billed for charges you believe you should not have to pay related to the types of services listed above, you may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint. You can also submit a complaint online at https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

If you want to learn more about your surprise billing rights and protections under federal law, visit https://www.cms.gov/nosurprises.

For purposes of these surprise billing protections, the following definitions apply:

- *"Emergency services"* are defined as services provided for a medical emergency that are considered covered services under the plan and are provided in an emergency department of a hospital or an independent freestanding emergency department, to evaluate, stabilize, and treat the patient. Covered services provided by an out-of-network provider or facility after a patient has been stabilized and as part of outpatient observation or a required inpatient stay immediately following and related to the illness or injury for which the emergency services were needed will also be considered emergency services unless all of the following conditions are satisfied:
  - The attending emergency physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available in-network provider or facility located within a reasonable travel distance, considering the patient's medical condition. The attending emergency physician's or treating provider's determination is binding;
  - The provider or facility furnishing out-of-network items and services after the patient has been stabilized satisfies the notice and consent criteria for the patient to waive the balance billing protections as prescribed by federal law with respect to such items and services;
  - The patient is able to receive notice and provide consent, as determined by the attending emergency physician or treating provider using appropriate medical judgment; and
  - The provider or facility satisfies any additional state law requirements or prohibitions.
- *"Air ambulance"* means medical transport by a rotary wing air ambulance or fixed wing air ambulance.
- *"Ancillary services"* means items and services provided by an out-of-network provider at an in-network facility that are related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an out-of-network provider if there is no in-network provider who can furnish the item or service at the in-network facility.

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 2-73.

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 use, 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 use, 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 certain medical services received outside your service area" section on page 2-97
- 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 2-112 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 2-63)
- 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 2-81
- 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 therapies not approved by the FDA, as well as any services, including drugs, procedures, and health care services related to them that introduce or are 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 2-112 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 2-43 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, unless determined to be medically necessary by the claims administrator
- 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 2-95
- 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 2-61
- 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 2-100 or required by applicable law
- Services for or related to tobacco cessation program fees or related program supplies (see "Quit For Life®" on page 2-36 for information about tobacco cessation)
- 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 2-100 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 2-75)
- 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 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 2-40.

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
Centivo	Phone: 1-833-666-1506

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 2-40.

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
Centivo	Phone: 1-833-666-1506	Centivo 199 Scott Street, Suite 800 Buffalo, New York 14204

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" section 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
Centivo	Centivo 199 Scott Street, Suite 800 Buffalo, New York 14204

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.

Claim denials and appeals

If you have a question or concern about a claim, you may call Included Health at 1-833-200-7683 or the applicable claims administrator:

- UnitedHealthcare at 1-800-842-9722
- Anthem BCBS at 1-866-418-7749
- Centivo at 1-833-666-1506

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 HSA Plan, Copay Plan with HRA, Local Copay Plan with HRA, 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.

Prescription drug benefit

The basics

Express Scripts, part of Evernorth Health Services, administers the prescription drug benefits offered under the:

- HSA Plan*
- Copay Plan with HRA*
- Local Copay Plan with HRA
- Flex HDHP

* Including Out of Area. Unless otherwise indicated, references in this "Prescription drug benefit" section to the HSA Plan and Copay Plan with HRA 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.

If you take an ongoing maintenance medication you are required to purchase your maintenance medication prescriptions as a 90-day supply from Express Scripts Home Delivery or at a CVS or Walgreens retail pharmacy. For more information see the "Maintenance medications" section on this page.

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 excludes medications that cannot be prescribed in a 90-day supply for clinical reasons (such as certain controlled substances). This also excludes drugs your doctor prescribes for a short-term condition, such as antibiotics.

You are required to get your maintenance medication prescriptions as a 90-day supply from Express Scripts Home Delivery or at a CVS or Walgreens retail pharmacy. Ensure your doctor writes the prescription for a 90-day supply.

- When you get your 90-day supply of prescribed maintenance medication at one of the three options listed above, you will pay the applicable copay (see the "What you'll pay for prescriptions: Copay Plan with HRA and Local Copay Plan with HRA" table on page 2-116, or the "What you'll pay for prescriptions: HSA Plan and Flex HDHP" table on page 2-117).
- If you do not get your 90-day supply filled at one of the three options listed above, you will pay 100% of the cost of the medication. This also applies to preventive medications that are considered maintenance medications even when they would normally be covered at 100%.
  - If you pay 100% of the cost, you will not be able to submit a claim to get reimbursed and the cost of the medication will not apply to any deductible or out-of-pocket accumulators.

If you are prescribed a new drug, you are allowed two courtesy 30-day retail fills. The courtesy fill limit resets when there is a dosage change in the medication. After your two courtesy 30-day supply fills, if you do not switch to the mandatory 90-day supply, you will pay 100% of the cost.

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 2-119 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 2-115 for more information.

Filling your prescription at a retail pharmacy

When you have your prescription filled at an in-network 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 Local Copay Plan with HRA" table on page 2-116, or in the "What you'll pay for prescriptions: HSA Plan and Flex HDHP" table on page 2-117, 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 on page 2-119 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 Local Copay Plan with HRA" table on page 2-116, or in the "What you'll pay for prescriptions: HSA Plan and Flex HDHP" table on page 2-117, for up to a 30-day supply per prescription, depending on the medical plan in which you are enrolled.

Note: If you purchase a maintenance medication at an out-of-network pharmacy, it will count toward the 2 courtesy fill limit for maintenance medications.

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 Local Copay Plan with HRA" table on page 2-116, or the "What you'll pay for prescriptions: HSA Plan and Flex HDHP" table on page 2-117)
- 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%. If the medication is a maintenance medication, the mandatory 90-day fill will apply. The cost will be $0 as long as you purchase a 90-day supply from a CVS or Walgreens retail pharmacy or through Express Scripts Home Delivery. 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 2-100)
- 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 2-88 and the "Women's preventive health care services" section starting on page 2-100 for information about other covered preventive care under the medical plan.

Patient Assurance Program℠

Wells Fargo participates in the Patient Assurance Program℠ administered by Express Scripts. When you fill a prescription for a participating product on the national preferred drug list your maximum out-of-pocket cost will be $75.00 for a 90-day supply only available at a CVS or Walgreens retail pharmacy or through Express Scripts Home Delivery (mail order). The products eligible for this program are typically defined as maintenance medications and will be required to be purchased from a CVS or Walgreens retail pharmacy or through Express Scripts Home Delivery. The $75.00 cap for a 90-day supplywill still apply. To confirm if your medication 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 products on the Patient Assurance Program℠ list are 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: the HSA Plan, the Copay Plan with HRA, or the Local Copay Plan with HRA.

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.

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.

SaveOnSP Program

If you participate in the Copay Plan with HRA or Local Copay Plan with HRA 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 1-800-683-1074 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.

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.

Note: In the HSA Plan 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 on page 2-119 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, 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.

- **Specialty drugs.** These are typically drugs that are self-injectable or require special handling, oral chemotherapy drugs, or drugs that treat complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis. For more information, see the "Accredo, your specialty pharmacy" section on page 2-119.

Note: 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. Biosimilars are typically less expensive than their originator, or reference, product.

What you'll pay for prescriptions: Copay Plan with HRA and Local Copay Plan with HRA

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 2-14 for more information about the annual deductible and annual out-of-pocket maximum. See the "No cost-share preventive medications" section starting on page 2-114 for more information about certain preventive drugs covered at 100%.

Note: You may use available HRA dollars for your eligible expenses. Refer to the "Using your HRA dollars" section starting on page 2-19 for more information.

Type of drug	**In-network retail pharmacy** (for short-term (acute) medication up to a 30-day supply)	**Out-of-network retail pharmacy** (for short-term (acute) medication up to a 30-day supply)	**Express Scripts Home Delivery** (for all covered medications up to a 90-day supply) **or CVS and Walgreens retail pharmacy** (for all covered medications 31- to 90-day supply)
Generic	You pay a $12 copay.[1, 2] **Note:** Generic contraceptives are covered at 100%.	You pay a $12 copay.[1, 2] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $24 copay.[1, 2] **Note:** Generic contraceptives are covered at 100%.
Preferred brand-name drugs	You pay a $60 copay.[1, 2, 3]	You pay a $60 copay.[1, 2, 3] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $120 copay.[1, 2, 3]
Nonpreferred brand-name drugs	You pay a $125 copay.[1, 2, 3]	You pay a $125 copay.[1, 2, 3] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $250 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 the following for a 90-day supply[1,2,3,4,5]: ◦ $150 copay for generic ◦ $450 copay for preferred brand-name drugs ◦ $600 copay for nonpreferred brand-name drugs **Note:** The copay is prorated for a 30- or 60-day supply of specialty medication.

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 for that medication as given 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 1-800-683-1074 to see if your drug is included in the program.

What you'll pay for prescriptions: HSA Plan and Flex HDHP

You must satisfy your applicable annual deductible under the HSA Plan 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 2-14 for more information about the annual deductible and annual out-of-pocket maximum. See the "No cost-share preventive medications" section starting on page 2-114 for more information about certain preventive drugs covered at 100%.

Type of drug	**In-network retail pharmacy** (for short-term (acute) medication up to a 30-day supply)	**Out-of-network retail pharmacy** (for short-term (acute) medication up to a 30-day supply)	**Express Scripts Home Delivery** (for all covered medications up to a 90-day supply) **or CVS and Walgreens retail pharmacy** (for all covered medications 31- to 90-day supply)
Medications on the preventive therapy drug list	You do not need to meet the deductible. You pay: • $12 copay for generic[1] **Note:** Generic contraceptives are covered at 100%. • $60 copay for preferred brand-name drugs[1, 2] • $125 copay for nonpreferred brand-name drugs[1, 2]	You do not need to meet the deductible. You pay: • $12 copay for generic[1] • $60 copay for preferred brand-name drugs[1, 2] • $125 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: • $24 copay for generic[1] **Note:** Generic contraceptives are covered at 100%. • $120 copay for preferred brand-name drugs[1, 2] • $250 copay for nonpreferred brand-name drugs[1, 2]
Generic	You pay a $12 copay after you satisfy the deductible. **Note:** Generic contraceptives are covered at 100%.	You pay a $12 copay after you satisfy the deductible. You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $24 copay after you satisfy the deductible. **Note:** Generic contraceptives are covered at 100%.
Preferred brand-name drugs	You pay a $60 copay after you satisfy the deductible.[2]	You pay a $60 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 $120 copay after you satisfy the deductible.[2]
Nonpreferred brand-name drugs	You pay a $125 copay after you satisfy the deductible.[2]	You pay a $125 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 $250 copay after you satisfy the deductible.[2]

Type of drug	In-network retail pharmacy (for short-term (acute) medication up to a 30-day supply)	Out-of-network retail pharmacy (for short-term (acute) medication up to a 30-day supply)	Express Scripts Home Delivery (for all covered medications up to a 90-day supply) **or CVS and Walgreens retail pharmacy** (for all covered medications 31- to 90-day supply)
Specialty medications (this includes infertility and fertility drugs)	Not covered.	Not covered.	Only covered through Accredo specialty pharmacy delivery. You pay the following for a 90-day supply after you satisfy the deductible[3]: ◦ $150 copay for generic ◦ $450 copay for preferred brand-name drugs ◦ $600 copay for nonpreferred brand-name drugs **Note:** The copay is prorated for a 30- or 60-day supply of specialty medication.

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 2-114 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:

- 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" section on this page.
- 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.
- If you attempt to fill a GLP-1 medication through Express Scripts Home Delivery, you will be directed to Evernorth Enguide Pharmacy, which is owned by Express Scripts, and designated to fill and ship GLP-1 medications to your home.
- 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 this page.
- Special rules may apply if you receive manufacturer assistance, see the "Manufacturer assistance programs/ out-of-pocket protection program" section on page 2-114 for more information.
- If you take a preventive medication on an ongoing basis you are required to fill it through Express Scripts Home Delivery or get a 90-day supply at a CVS or Walgreens retail pharmacy. For more information, see the "Maintenance medications" section on page 2-112.

Your ID card

Shortly after you enroll in the HSA Plan, the Copay Plan with HRA, the Local Copay Plan with HRA, 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 Local Copay Plan with HRA" table on page 2-116 or the "What you'll pay for prescriptions: HSA Plan and Flex HDHP" table on page 2-117 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 in the table beginning on page 2-121. 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 Local Copay Plan with HRA" table on page 2-116 or the "What you'll pay for prescriptions: HSA Plan and Flex HDHP" table on page 2-117. 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		
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
Emphysema	X		X

Drug class or condition treated	Pre-service authorization required	Step therapy required	Quantity limits apply
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
PAH endothelin-receptor agonists	X	X	

Drug class or condition treated	Pre-service authorization required	Step therapy required	Quantity limits apply
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
Substance use	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 or Walgreens retail pharmacy. 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 unless prohibited by law.
- 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 or Walgreens retail pharmacy, even if there is not a CVS or Walgreens retail pharmacy 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 either the HSA Plan, the Copay Plan with HRA, the Local Copay Plan with HRA, or the Flex HDHP 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 2-43).
- 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 either the HSA Plan, the Copay Plan with HRA, the Local Copay Plan with HRA, 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 2-109.

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 the HSA Plan, the Copay Plan with HRA, the Local Copay Plan with HRA, 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.

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 Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 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: Other 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 SPD is a summary of provisions for the dental plan. The Health Plan (including the dental plan) is a group health plan and is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Two dental coverage options are available in all U.S. locations:

- Delta Dental Standard
- Delta Dental Enhanced

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.

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.

Dental coverage highlights

The dental plan provides coverage for:

- Preventive cleanings and exams
- Basic restorative care (such as fillings)
- Major restorative care (such as crowns)
- Orthodontia coverage

The difference between the standard and enhanced options is the amount the plan will pay toward eligible covered services and the maximum benefits payable under the plan. See the "What the Delta Dental coverage options cover" section starting on page 3-6 for detailed benefits and coverage information.

You must be enrolled in one of the dental coverage options on the date of service to receive applicable benefits.

As always, it is between you and your provider to determine the services and supplies you will receive. The provisions governing your dental plan control what, if any, benefits are available for the services you receive. The fact that a dental provider 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 covered under the plan.

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 by one employee.

How to enroll and when coverage begins

See the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for Enrollment as a new hire, rehire, or if you have an employment classification change and become eligible to enroll in benefits. 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

If you did not enroll when first eligible or you want to make changes to your enrollment election, you may do so during the Annual Benefits Enrollment period or if you experience certain Qualified Events during the year. For more information on making enrollment election changes, see the "Changing coverage" section in "Chapter 1: Eligibility, Enrollment, and More."

You must drop your dependent from coverage in Workday when they no longer meet eligibility requirements. See the "You must drop ineligible dependents" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

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, see the "Cost and funding" section in "Chapter 1: Eligibility, Enrollment, and More."

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 Dental 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 3-7 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 3-10.

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 3-7 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 either the treating provider's submitted charge or the amount 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 the deductible or annual maximum for services listed in the "Diagnostic and preventive care" section on page 3-7.
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. See the "Orthodontia benefits" section on page 3-8 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 3-6. 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 amount established by Delta Dental. When services are received from an out-of-network provider, you must file the claim, and claim payments are sent directly to you, unless benefits are authorized by the Covered Person to be paid directly to the provider and required by applicable state law. 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 3-6. 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 casts performed in preparation for orthodontia treatment and in complex treatment cases by general dentists
- 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; silver diamine fluoride is covered twice per calendar year, per tooth

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.
- Occlusal guards (also known as night guards), once every five years.
- 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.

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. The total lifetime orthodontia benefits paid per person, combined with any other orthodontia benefits paid under the Wells Fargo dental plan 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:

- 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
- Re-cement or re-bond fixed retainer is allowed once per lifetime, only when administered by a dental office that did not place the braces
- Replacement of lost or broken retainers are allowed once per lifetime, only after 12-months following the completion of orthodontic treatment
- Removable, fixed, or cemented habit-breaking appliances (including adjustment and treatment of appliances), limited to one appliance per covered member

It is recommended that you obtain a pretreatment estimate, as described under the "Pretreatment estimate" section starting 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 3-10.

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 3-7
- 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, unless listed in the "Orthodontia benefits" section on page 3-8
- Replacement of existing dentures or bridgework, unless listed in the "Major care" section on page 3-8
- 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 starting 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.

After six months of ongoing treatment, 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.

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.

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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 Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 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: Other 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 SPD is a summary of provisions for the vision plan. The Health Plan (including the vision plan option) is a group health plan and is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

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.

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.

Vision coverage highlights

The vision plan provides coverage for:

- Periodic vision exams
- Prescription glasses (frames and lenses) or contacts

See the Your vision plan benefits and costs at a glance "Your vision plan benefits and costs at a glance" section on page 4-5 and "What the vision plan covers" section starting on page 4-6 for details. You must be enrolled in the vision plan on the date of service to receive benefits.

As always, it is between you and your provider to determine the services and supplies you will receive. The provisions governing the vision plan control what, if any, benefits are available for the services you receive. The fact that an ophthalmologist, optometrist, or other vision service provider 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 covered under the plan.

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 by one employee.

How to enroll and when coverage begins

See the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment as a new hire, rehire, or if you have an employment classification change and become eligible to enroll in benefits. 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

If you did not enroll when first eligible or you want to make changes to your enrollment election, you may do so during the Annual Benefits Enrollment period or if you experience certain Qualified Events during the year. For more information on making enrollment election changes, see the "Changing coverage" section in "Chapter 1: Eligibility, Enrollment, and More."

You must drop your dependent from coverage in Workday when they no longer meet eligibility requirements. See the "You must drop ineligible dependents" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

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 plan coverage. For more information, see the "Cost and funding" section in "Chapter 1: Eligibility, Enrollment, and More."

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 on 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[1]	Out-of-network benefits
Eye exams (limited to once every calendar year)	You pay a $10 copay.	Vision plan pays up to $45 after you pay a $10 copay.
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.[2]	You pay a $15 copay only once per calendar year, for lenses or frames, whether purchased together or separately.[2] 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. However, the vision plan pays $95 toward a frame of your choice at Costco or Walmart 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.[2]	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.[2]
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.

1. Not all listed services are available from some participating retail chains. Contact VSP for details.

2. 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 when you receive frames from a VSP network provider; however, the vision plan pays $95 toward a frame of your choice at Costco or Walmart after you pay a $15 copay (see the "Your vision plan benefits and costs at a glance" table on page 4-5). 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+) 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+ 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+ 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
  - Oversized 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+:

- 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 may file the claim by submitting VSP's claim form. For a copy of the claim form, visit wf.vspforme.com or call 1-877-861-8352.

To file a claim, send the claim form, along with the itemized receipt, within 12 months of the date of service to:

Vision Service Plan
Attn: Claims Services
PO Box 495918
Cincinnati, OH 45249-5918

You may also file a claim from an out-of-network provider by logging into your VSP account at wf.vspforme.com.

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	www.healthequity.com (Log into EZ Receipts) 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: Other 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 or "the Plan").

The basics

General Information

The SPD is a summary of provisions for the Health Care FSA Plan. The Health Care FSA Plan is a group health plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Under the Health Care FSA Plan, you can elect to contribute to one of the following accounts that can be used to pay for eligible expenses:

- Full-Purpose Health Care Flexible Spending Account (Full-Purpose Health Care FSA)
- Limited Dental/Vision Flexible Spending Account (Limited Dental/Vision FSA)

Each type of FSA may be referred to simply as an "FSA" throughout this chapter.

Claims administrator

HealthEquity is the claims administrator and processes requests for reimbursement from your FSA. HealthEquity is the named claims and appeals fiduciary and has the sole and complete discretionary authority to determine if benefits are payable in accordance with the terms of the Plan.

Health Care FSA Plan highlights

Regular and fixed term employees can choose to enroll in one of the following Health Care FSA Plan options, which cover different types of eligible expenses.

	Full-Purpose FSA	Limited Dental/Vision FSA
What expenses are eligible?	Eligible medical, prescription drug, dental, and vision expenses	Eligible dental and vision expenses only
Who may want to enroll?	You may want to elect the Full-Purpose Health Care FSA if you waive medical coverage or if you enroll in the Wells Fargo Copay Plan with HRA, the Local Copay Plan with HRA, or a Kaiser HMO option. Enrollment in this account makes you ineligible to contribute to an Health Savings Account (HSA). This means that if you are enrolled in a high deductible health plan and you want to contribute to a HSA, you should not enroll in this option. See the "Decision to participate" section on page 5-4 for more information.	You may want to elect the Limited Dental/Vision FSA if you are enrolled in the Wells Fargo HSA Plan or a high deductible health plan through a spouse's or domestic partner's plan. Another reason you may want to elect the Limited Dental/Vision FSA is if you want the funds to be used solely for dental or vision expenses and do not want the funds used for medical or prescription drug expenses. Enrollment in the Limited Dental/Vision FSA will not affect your eligibility to contribute to a Health Savings Account (HSA).
How are contributions made?	When you enroll in either option, you elect to make before-tax contributions through payroll deductions, which are taken each pay period. See the "Your contributions" section on page 5-5 for more information.	
How can I pay using this account?	You can use your HealthEquity® Visa® Card (Card) to pay for eligible expenses at the time of service. You may also submit a "Pay My Provider" request, or you can file a claim to be reimbursed later. For more information see the "Using the Card to pay for eligible expenses" section on page 5-10, the "Pay My Provider (PMP) payment option" section on page 5-11, and the "Claims and appeals" section on page 5-11.	

Decision to participate

Your decision to participate in the Health Care FSA Plan is voluntary and should be based on your needs and personal situation.

Your contributions to, and reimbursements from, the FSA are designed to qualify for favorable tax treatment by the IRS. When you file your tax returns, you cannot deduct or claim a tax credit for expenses reimbursed by the FSA. 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 return or enrolling in the FSA is more favorable to you — consult a tax advisor.

You have a limited time to incur eligible expenses. See the "Time frame for incurring eligible (qualified) expenses" section on page 5-9 for details.

You may lose money. Any balance remaining in your FSA after the filing deadline for the plan year will be forfeited and cannot be rolled over to another year or paid out to you. For more information on the claims filing deadline, see the "Claims filing time frame" section on page 5-12.

The information below regarding HSA contributions is not part of the Health Care FSA Plan or its SPD and is provided for informational purposes only. HSAs are individually owned accounts and are not subject to ERISA.

- **Important consequences to your HSA eligibility if you elect a Full-Purpose Health Care FSA.** 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 HSA (including employer contributions, if otherwise eligible, and earned health and wellness dollars). You may, however, enroll in the Limited Dental/Vision FSA rather than the Full-Purpose Health Care FSA which will allow you and Wells Fargo to be able to contribute to your HSA.
- **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 contribute to an HSA next year (assuming you 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 be eligible 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 the new plan year, if you have a balance remaining in your Full-Purpose Health Care FSA on December 31, per IRS requirements. In addition, if you have a balance in your Full-Purpose Health Care FSA on December 31, any medical expenses that you, your spouse, or other eligible tax dependents incur between January 1 and March 31 of the following year will not be considered qualified medical expenses eligible for reimbursement from your HSA, even if you're enrolled in a high deductible health plan.
  - It is your responsibility to manage your balance and allow ample time for all transactions (including, but not limited to, Card transactions and expense substantiation) to be fully processed before December 31.

Who's eligible

Regular and fixed term Wells Fargo employees are eligible to enroll in an FSA. Interns, flexible employees, and dependents are not eligible to enroll in or contribute to an FSA. 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

See the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment as a new hire, rehire, or if you have an employment classification change and become eligible to enroll in benefits. After you have enrolled, coverage will begin as described in the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More". See the "Your contributions" section on page 5-5" for the amount you can elect and other events impacting your contributions. Before you enroll, be sure to understand all the rules and limitations of using the FSA as explained in this chapter, including the potential to lose money you have contributed.

You must make new contribution elections each year during Annual Benefits Enrollment. Participation in either FSA does not continue automatically from year to year. If you want to participate again the following year, you must make a new annual contribution election during each Annual Benefits Enrollment period for the FSA that becomes effective January 1 of the following year. When you enroll during the Annual Benefits Enrollment period, Wells Fargo credits your 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.

Your contributions

Electing a contribution amount

You can elect annual contributions in any whole dollar amount with a:

- Minimum of $130 per plan year or $5.00 per pay period
- Maximum of $3,300 per plan year

Note: If you are married and your spouse works at Wells Fargo and is eligible for the FSA, each of you can participate as employees and elect the maximum amount.

Making your contributions

When you elect an annual FSA contribution amount, you authorize contributions to be taken from your pay before federal and most state taxes are withheld.

Your before-tax pay will be reduced each pay period by the per-pay-period contribution amount, which is the annual election divided by the number of eligible pay periods during the plan year. 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, your before-tax pay will be reduced by additional amounts until your outstanding past due balance is zero, or the last paycheck of the year, whichever comes first. For more information on past-due amounts, see the "Paying for coverage — regular and fixed term employees" section in "Chapter 1: Eligibility, Enrollment, and More."

Each FSA is a notional bookkeeping account established to keep track of your contributions and reimbursements. You do not actually have a bank account into which contributions are deposited and reimbursements are withdrawn.

Contributions while on leave of absence

If you are on an approved leave of absence, see "Appendix D: Leaves of Absence and Your Benefits," for information on the impact to your FSA contributions during a leave of absence.

Impact of employment status changes on your contributions

If you begin participating in the FSA and then cease to be eligible (e.g. you terminate employment or you change your employment classification to an ineligible position) your FSA enrollment terminates at the end of the month after the change in employment status. You may, however, still submit claims, for expenses incurred before your enrollment terminated; you have until April 30 of the following year to file claims. You may be eligible to continue participation in your FSA for the remainder of the plan year under COBRA. For more information, see the "COBRA coverage" section starting on page 5-6.

If you are an intern or flexible employee and change your employment classification to regular or fixed term, you become eligible to enroll in the FSA. See the "How to enroll and when coverage begins" section on page 5-4 for more information.

Rehires and re-enrollments within the same plan year

If you cease to be eligible for the Health Care FSA Plan and then become eligible again during the same plan year (you are rehired as an eligible employee or you return to an eligible employee classification), you may re-enroll subject to the following conditions:

- If you become eligible again in the same plan year and within 30 days of being previously enrolled, your previous FSA election will be reinstated. You do not get to make a new contribution election.
- If you become eligible again more than 30 days after ceasing to be eligible, you may make a new election. However, if you become eligible again more than 30 days after ceasing to be eligible and *during the same plan year*, the most you can elect is the maximum election (identified above in "Your contributions") reduced by contributions you made before you ceased to be eligible during the same plan year. For example, if you contributed $500 before you ceased to be eligible, then you could only elect $2,800 ($3,300 - $500) for the remainder of the plan year. Also, any unused contributions from your prior period of eligibility during the same plan year cannot be used for expenses incurred during your subsequent period of eligibility.

Changing contributions

IRS regulations restrict your ability to change your contributions to your FSA during the plan year. You cannot change your contribution amount to your 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."

- If you experience a Qualified Event and you increase your elected contributions, claims incurred prior to the date you increased your election will be subject to the original election 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 $1,300 elected during Annual Benefits Enrollment.
  - If you assume 26 pay periods during the plan year, your pay period contribution is $50.
  - As a result of a Qualified Event, you elect on September 24 to increase your annual contribution amount to $2,600 effective October 1.
  - You contributed $1,000 in 20 pay periods prior to the effective date of the election change. Since there are only 6 pay periods remaining, your per-pay-period contributions will be increased from $50 to $266.67 for the remainder of

the plan year ($2,600 minus $1,000 contributed in the prior 20 pay periods is $1,600 which is then divided by the remaining 6 pay periods).

  - Expenses incurred before October 1 are subject to the original $1,300 election amount (reduced by reimbursements) regardless of when submitted. Expenses incurred on or after October 1 are subject to the new $2,600 election (reduced by prior reimbursements).

- If you experience a Qualified Event and you wish to revoke your election, you can; however, expenses incurred after the first of the month following your election change will not be eligible for reimbursement and you will lose any contributions not used for expenses incurred prior to the election change date.
- If you experience a Qualified Event and you want to decrease your annual contribution amount but you want to continue your participation in your 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. 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 FSA contribution election is $1,950.
  - If you assume 26 pay periods per plan year, your per-pay-period contribution is $75.
  - As a result of a Qualified Event, you elect on September 24 to decrease your annual contribution to $1,600 for the plan year, effective October 1.
  - You contributed $1,500 in the 20 pay periods prior to the effective date of your election change. Since there are only 6 pay periods remaining, your per-pay-period contribution decreases from $75 to $16.67 for the remainder of the year ($1,600 minus $1,500 contributed in the prior 20 pay periods is $100 which is then divided by the remaining 6 pay periods).
  - Expenses incurred prior to October 1 are subject to the original $1,950 election (reduced by prior reimbursements) regardless of when submitted. Expenses incurred on or after October 1 are subject to the new $1,600 election (reduced by prior reimbursements).

- If you experience a special enrollment event or Qualified Event that allows you to elect a different medical benefit option midyear, you are not allowed to make a midyear election change from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa, even if you enroll in the HSA Plan option midyear.
- If you have a mid-year special enrollment right or Qualified Event allowing you to enroll in the HSA Plan in order to be able to make contributions to an HSA, you must make a corresponding election to drop your Full-Purpose Healthcare 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 HSA. Not all Qualified Events permit you to drop your Full-Purpose Health Care FSA.

When participation ends

Participation in your 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: Other Notifications and Disclosures."

You may continue to file claims for eligible expenses incurred before the date your participation ends until April 30 of the next calendar year.

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. If you (the enrolled employee) pass away, 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.

In order to elect COBRA continuation coverage, the total year-to-date FSA contributions at the time of the COBRA qualifying event must be greater than the amount of your eligible expenses that have been reimbursed 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 that have been reimbursed 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 so long as you continue to make timely COBRA payments. Participation will cease before the end of the plan year if you stop making COBRA payments. If you do stop making timely COBRA payments, your participation in the FSA will end before your COBRA eligibility and before the end of the plan year.

For more information about COBRA coverage, see "Appendix E: Continuing Coverage Under COBRA."

Eligible (or qualified) expenses

General expense criteria

To be eligible for reimbursement or payment from your FSA, the expense must:

- Be incurred by you or your eligible dependents. An eligible expense is incurred when services are received, not when they are paid to the provider.
- Be for "medical care" as defined in Internal Revenue Code Section 213(d).
- Not be reimbursed by any other source.

Eligible dependents are:

- Your spouse
- Your domestic partner, **only** if they qualify as your tax dependent under the Internal Revenue Code
- Your child, as defined in Internal Revenue Code Section 152(f)(1), including adult children up to age 26*
- Any other person who qualifies as your dependent in accordance with Internal Revenue Code Section 152 (as modified by Code Section 105)

* 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.

Full-Purpose Heath Care FSA and Limited Dental/Vision FSA expenses

Full-Purpose Health Care FSA	Limited Dental/Vision FSA
The expense must be for medical, prescription drug, dental, or vision care as defined in Internal Revenue Code Section 213(d) (except for insurance premiums and qualified long-term care services), 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 • Eligible over-the-counter drugs and menstrual care products	The expense must be for dental or vision care as defined in Internal Revenue Code Section 213(d), such as: • Copayments, coinsurance, and deductibles for eligible dental and vision expenses • Dental and orthodontic expenses • Vision expenses and LASIK surgery **Note:** 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.
The HealthEquity website at www.healthequity.com (Log into EZ Receipts) 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).	

The importance of keeping receipts

Because the Health Care FSA Plan is an IRS-regulated benefit, you should save all of your related itemized receipts. HealthEquity may contact you to submit a receipt to verify an expense — especially if you paid for the expense with your HealthEquity® Visa® Card.

Letter of Medical Necessity

Some expenses are for services, treatments, or supplies that can qualify as medical care or personal care depending on how they are used. If there is an expense shown as "Yes (Letter)" in the Covered column on the eligible expense list at www.healthequity.com (Log into EZ Receipts), you must submit a letter from your provider with your reimbursement request explaining that the service was to treat an eligible medical or mental health condition. A Letter of Medical Necessity form is available on the member portal and can be downloaded to ensure all information necessary is included.

Ineligible expenses

The FSAs do not allow reimbursements for certain specific expenses, including but not limited to the items listed below. The ineligible expenses listed below apply to either the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, as applicable. **Note: 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:
  - 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)
  - Drugs and over-the-counter products are not eligible under the Limited Dental/Vision FSA, except for a limited few (see the eligible expense list on HealthEquity's website at www.healthequity.com [Log into EZ Receipts])
  - Exercise, athletic, or health club membership (except as noted under Eligible Expenses on www.healthequity.com [Log into EZ Receipts])
  - Household help
  - Nursing care for a healthy baby

  - Weight loss programs (except as specifically described under Eligible Expenses on www.healthequity.com [Log into EZ Receipts])
- 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 before your effective date of participation in the FSA
- Expenses incurred after the Health Care FSA Plan ends or your participation in the FSA ends
- Expenses not allowed as a deduction or credit for federal income tax purposes
- Expenses paid for with HRA or HSA dollars
- Expenses paid for or reimbursed by another source
- Expenses you also claim as a deduction or credit for federal or state income tax purposes
- Expenses for qualified long-term care insurance services
- Medical and prescription drug expenses if you are enrolled in the Limited Dental/Vision FSA
- Premiums or contributions for health coverage
- Premiums for insurance

Time frame for incurring eligible (qualified) expenses

You have a limited timeframe for incurring eligible (qualified) expenses.

An 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. However, orthodontia initial fees or down payments are eligible for reimbursement with an orthodontia contract that shows the exact charge with the contract date. Alternatively, an itemized payment receipt can also be submitted.

You must incur the expenses:

1. While you are participating in the FSA. **Note:** You can claim eligible expenses incurred during your approved leave of absence, as long as you are still participating in the FSA.
2. In the same plan year you are contributing to the applicable FSA or within the grace period as described below.

Grace period. If you are enrolled in either FSA option 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 following year. This grace period extends the time period during which you can incur eligible expenses that can be reimbursed with contributions from the prior plan year. 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.
Note: Card use must occur prior to the March 15 at 11:59 p.m. Central Time grace period deadline in order to apply to the prior year. Any Card use after the March 15 at 11:59 p.m. 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, 2025. You incur $100 worth of eligible expenses on January 15, 2026, and submit a request for reimbursement on January 30, 2026. At that time, you have a $50 balance still remaining in your 2025 Full-Purpose Health Care FSA. Accordingly, $50 of your $100 eligible expenses will be reimbursed to you from your 2025 account and the remaining $50 may be eligible to be reimbursed from your 2026 account if you have elected the Full-Purpose Health Care FSA for 2026.

How to pay for eligible expenses with your FSA

Options	Best used when:	Additional details can be found
HealthEquity® Visa® 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 the Card to pay for eligible expenses" section on this page
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 5-11
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 5-11

HealthEquity® Visa® Card

Receiving your Card

When you enroll in either FSA option, you will automatically receive a HealthEquity® Visa® Card (Card) generally within two weeks of your enrollment date or early the following year if you enroll during Annual Benefits Enrollment (if you do not receive your Card, contact HealthEquity). You may request additional Cards for a spouse or adult-aged (18 or older) eligible dependents by visiting www.healthequity.com (Log into EZ Receipts), 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 gives you a convenient way to pay for qualified expenses directly from your FSA. Read the Terms and Conditions of Use that you receive with your card before using the Card; the Terms and Conditions of Use are not a part of this SPD.

Replacement Cards, forgotten or stolen PINS, and disputed transactions

Call HealthEquity at 1-877-924-3967 immediately if your Card is lost or stolen or if you believe that someone has gained unauthorized access to your PIN. You can also call this number if you forget your PIN or have additional questions about the Card. If you wish to dispute a transaction, see the Terms and Conditions of Use included with your Card for more information on your right to dispute a Card transaction.

Using the Card to pay for eligible expenses

Your Card can be used to pay for qualified out-of-pocket expenses at merchants that accept Visa® or NYCE Cards. Refer to the Terms and Conditions of Use included with your Card for information on the different terms that apply when a transaction is processed as a Visa® debit transaction or as a NYCE transaction.

- Your Card can only be used to pay exact amounts you owe for qualified expenses. If your purchase includes nonqualified expenses, you must pay for those items separately with another form of payment.
- You can use the Card to pay a bill for qualified expenses. Write the Card number on your statement and send it back to the provider. Payment will be taken directly from available funds in your FSA as applicable and paid to the health care provider for eligible expenses.
- 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.

When using your Card, keep the following in mind:

- You certify during the applicable election period that you and any other cardholders will only use the Card to pay for eligible health care expenses, that you have not been reimbursed for the expense from another source, and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of Card use privileges.
- Every time you swipe the Card, you certify to the Plan that the expense that you are paying for with the Card is an eligible medical expense, that you have not been reimbursed from any other source (e.g. other health insurance) and that you will not seek reimbursement from another source.
- Use of the Card for eligible medical expenses is limited to merchants identified by HealthEquity as having a specific health care merchant category code, certain pharmacies that meet IRS requirements for FSA Card use, and merchants that are participating in the Inventory Information Approval System (as defined by the IRS). If you have questions about whether the Card will work at a specific merchant, contact HealthEquity.
- You must obtain a third-party statement from the merchant (e.g., receipt or invoice) that includes information verifying that the expense was eligible. For more information, see the "Required expense documentation" section on page 5-12. This statement provides substantiation required by the IRS that the expense is for an eligible expense. You should retain

this statement for at least one year following the close of the plan year in which the expense is incurred. In accordance with IRS guidance, some of the expenses that you pay for with the Card will not require additional substantiation. However, many expenses that you pay for with the Card will require additional substantiation as required by the IRS.

It is your obligation to regularly check to see if you have any Card transactions that need verification; access your account at www.healthequity.com (Log into EZ Receipts). 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.

- If you are unable to provide adequate or timely substantiation as requested by HealthEquity, your Card privileges will be suspended until the correction process is completed (even if the correction is not completed until the subsequent plan year). Under the correction process, you must repay the plan for the unsubstantiated expense. You can either repay the plan with your own funds or, if eligible expenses are submitted for reimbursement, those expenses will be offset by the amount of any unsubstantiated claims. You generally must submit the required documentation for your eligible expense or repay the unsubstantiated transaction by the claims filing deadline for the plan year (or repay by such later date identified by Health Equity). If you have not repaid the amount or if the amount is not offset by other eligible expenses, then the amount may be withheld from your pay (as specified in the Cardholder Agreement and as permitted by applicable law) or the remaining unpaid amount may be treated by Wells Fargo in accordance with IRS guidelines, which may result in additional taxable gross income for you.

Coordination between Health Care FSA and the Copay Plan with HRA or the Local Copay Plan with HRA expenses

You will receive one HealthEquity® Visa® Card to access the FSA balance or the HRA balance, or both, as applicable.

New starting January 1, 2026:

Your available Full-Purpose Health Care FSA balance will be used first to pay for all eligible expenses. The FSA balance will be used first even if you have an HRA because you are enrolled in either the Copay Plan with HRA or Local Copay Plan with HRA. When your Full-Purpose Health Care FSA funds are completely exhausted, only then will your available HRA balance be applied to eligible medical and pharmacy expenses covered by the Copay Plan with HRA or Local Copay Plan with HRA. If you want a claim that was paid out of the Full-Purpose Health Care FSA for eligible medical or prescription drug expenses to be paid from your HRA balance, you can call HealthEquity to request that adjustment. You may be required to provide an Explanation of Benefits to substantiate the eligible expense under HRA.

Pay My Provider (PMP) payment option

Pay My Provider (PMP) gives you the ability to have HealthEquity make a payment directly from your FSA to your provider for eligible expenses. You can request a one-time or recurring payment. PMP requests may not be entered before the service start date.

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 FSA. You are permitted to enter a requested payment date that is up to 10 calendar days before the due date shown on the contract. You must submit an itemized invoice or other appropriate proof of service before PMP payments can be issued. The payment request will remain in the system until the documentation is submitted.

See the "Required expense documentation" section on page 5-12 for more information regarding the information required to be submitted. One-time requests will be processed and distributed just a few days after the submitted invoice or documentation has been received and approved by HealthEquity. A one-time payment cannot be canceled once it is submitted.

Recurring payments will be mailed on the requested payment date, 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. A recurring payment, unlike a one-time payment, may be canceled up to 10 days before the requested payment date by calling HealthEquity or on the member website.

To request a PMP payment, sign on to www.healthequity.com (Log into EZ Receipts), 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.

Claims and appeals

General Claims information

If you did not use your Card or the Pay my Provider option to pay for eligible expenses, you will need to file a claim for reimbursement. See the "Filing a claim" section starting below for claims filing procedure details.

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 your FSA, file a completed Pay Me Back claim form and submit the required expense documentation to the claims administrator, HealthEquity.

The claim form is available to you online. You can access the HealthEquity website at www.healthequity.com (Log into EZ Receipts).

You may file your claim by one of the following methods:

- Using the website, you can complete an online claim form at www.healthequity.com (Log into EZ Receipts), and upload your scanned supporting expense documentation for your claim submission.
- You can use the HealthEquity mobile app. 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:

  Claims Administrator — HealthEquity
  PO Box 14053
  Lexington, KY 40512

See the "Required expense documentation" section on this page for more information about what to submit with your claim form.

Claims filing time frame

Claims for expenses incurred during a plan year (or applicable grace period — see the "Time frame for incurring eligible (qualified) expenses" section on page 5-9) must be postmarked, faxed, or electronically filed as noted above by April 30 at 11:59 p.m. Central Time of the following 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. 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.

Claims or expense documentation submitted after the April 30 at 11:59 p.m. Central Time deadline will not be reimbursed.

If, following the April 30 at 11:59 p.m. Central Time deadline, you have a remaining balance in your 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 or receive a refund. For example, if you have not filed for reimbursement of your eligible expenses for your 2026 FSA option by April 30, 2027, at 11:59 p.m. 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 Plan and for the benefit of plan participants and their dependents. You cannot receive a refund for the unused balance.

Required expense documentation

Required expense documentation includes all of the following required by the IRS:

- Patient name
- Provider name
- Date of service
- Type of service
- Your cost (your copayment, coinsurance, deductible amount, or the portion not covered by your insurance)

Types of documentation that may qualify include Explanation of Benefits provided by health insurance companies or claims administrators in connection with a health plan claim or the receipt from the merchant (e.g. where you have paid with a card). A copy of a check does not qualify. 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.

Some expenses require a Letter of Medical Necessity (when noted as a requirement on the eligible expense list on HealthEquity's website at www.healthequity.com (Log into EZ Receipts) — see the "Letter of Medical Necessity" section on page 5-8 for more information).

Claim payment

Your eligible claims will be paid up to your current account balance. The total annual contribution amount you elect to contribute to your FSA for the plan year is available for you to use as of your effective date for the plan year (January 1 following an Annual Benefits Enrollment FSA election or your effective date of coverage for midyear FSA enrollments). As a result, your "current account balance" at any point during the plan year is the elected annual contribution amount less any claims paid.

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 in the following order, as shown in Workday by clicking Pay > Payment Elections > Distribution column:

1. Balance account
2. Account with largest percent if no balance account
3. Top row if no balance account but percentages are equal

If you receive your pay by check, you'll receive your reimbursement 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.

FSA questions, denied reimbursement, and appeals

If you have a question or concern about the 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 FSA appeals is provided in "Appendix A: Claims and Appeals."

Account activity and status

Access your account online to review and print your real-time account information at any time. 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 www.healthequity.com (Log into EZ Receipts) or by calling HealthEquity at 1-877-924-3967.

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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	www.healthequity.com (Log into EZ Receipts) 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: Other 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 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 $7,500 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 $3,000. 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, 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, 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 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 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 eligible 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. 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, 2025, you incur $100 worth of eligible day care expenses on January 15, 2026, and you submit a request for reimbursement on January 30, 2026. At that time, you have a $50 balance still remaining in your 2025 Day Care FSA. Accordingly, $50 of your $100 eligible day care expenses will be reimbursed to you from your 2025 account and the remaining $50 may be eligible to be reimbursed from your 2026 account if you have elected the Day Care FSA for 2026.
- 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 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. A claim can also be filed online at www.healthequity.com (Log into EZ Receipts) to request reimbursement for eligible expenses.
- 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 service is received, not when you pay the provider. For example, if you pay for 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, additional contributions, up to the extent permitted by applicable law, will be deducted from your pay until your outstanding past due balance is zero, or the last paycheck of the year, whichever comes first. For more information on arrears, see the "Paying for coverage — regular and fixed term employees" 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. (This description assumes your rehire date is not within 30 days of your termination date.)

  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 October 1 with coverage effective October 1. You are eligible to elect $7,038.46 ($7,500 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 $2,538.46 ($3,000 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 $7,500 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 $7,500 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 $7,500 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 $7,500 per year, subject to the other limitations imposed by applicable IRS guidance. You and your spouse cannot claim the same expenses. 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 $3,000 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: • $7,500 • Your earned income
Married and file a joint tax return	The lesser of: • $7,500 • 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: • $3,750 • 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**	The lesser of: • Your earned income • Your spouse's earned income (real or deemed) • The statutory limit ($7,500 starting in 2026) If your spouse is a full-time student or incapable of self care, they are deemed to earn: – $250 per month if you have one qualifying dependent – $500 per month if you have two or more qualifying dependents

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 your date of hire in a regular or fixed term position or the date of your employment classification change. 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. If you experience an employment classification change, your participation will be effective on the date of your employment classification change, if you make your election during your designated enrollment period. If you are rehired within 30 days of your termination, your Day Care FSA election that was in effect on your date of termination will be reinstated.

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 to an intern or flex position

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 (additional contributions, up to the extent permitted by applicable law, will be deducted from your pay until your outstanding past due balance is zero, or the last paycheck of the year, whichever comes first). For more information on arrears, see the "Paying for coverage — regular and fixed term employees" 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 eligible 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 (additional contributions, up to the extent permitted by applicable law, will be deducted from your pay until your outstanding past due balance is zero, or the last paycheck of the year, whichever comes first).

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: Other 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, preschool, 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

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 or preschool 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 www.healthequity.com (Log into EZ Receipts). You may file your claim by one of the methods noted below:

- Using the website, you can complete an online claim form at www.healthequity.com (Log into EZ Receipts) 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 www.healthequity.com (Log into EZ Receipts).
- 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 2026 Day Care FSA by April 30, 2027, any remaining 2026 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.

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 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 in the following order, as shown in Workday by clicking Pay > Payment Elections > Distribution column:

1. Balance account

2. Account with largest percent if no balance account

3. Top row if no balance account but percentages are equal

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.

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 www.healthequity.com (Log into EZ Receipts) 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 www.healthequity.com (Log into EZ Receipts) 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 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 Appeals
PO Box 14034
Lexington, KY 45012

HealthEquity will review your request and issue the final determination to you.

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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 filing 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 form 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: Other 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 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"). 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.

If you'd like a free copy of the certificate, you may contact Employee Care (see the "Contacts" section on page 7-2). **Note:** Individual certificates are not available.

The Life Insurance Plan is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The deceased must be enrolled in the applicable coverage option under the Life Insurance Plan on the date of death and the claim promptly filed to receive applicable benefits under the plan.

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 whether benefits are payable under the Life Insurance Plan and respective coverage options.

Life Insurance Plan highlights

The Life Insurance Plan offers four types of term life insurance coverage:

- **Basic Term Life (for employees)**
  - Regular and fixed term employees are automatically enrolled in Basic Term Life insurance coverage, no election required.
  - You are covered for one times your covered pay (see the "Covered pay" section on page 7-10 for more information).
    - Minimum plan benefit: $10,000
    - Maximum plan benefit: $50,000
  - You designate a beneficiary
  - Wells Fargo pays the premium
- **Optional Term Life (for employees)**
  - Regular and fixed term employees can elect to enroll in Optional Term Life insurance coverage for an additional one to ten times covered pay on themselves.
    - Minimum plan benefit: $10,000
    - Maximum plan benefit: $3,000,000
  - You designate a beneficiary
  - You pay the premium
- **Spouse/Partner Optional Term Life**
  - Regular and fixed term employees can elect to enroll in Spouse/Partner Optional Term Life insurance coverage to provide life insurance coverage on their eligible spouse or domestic partner in $25,000 increments.
    - Minimum elected benefit: $25,000
    - Maximum elected benefit: $250,000
  - You are the beneficiary
  - You pay the premium
- **Dependent Term Life**
  - Regular and fixed term employees can elect to enroll in Dependent Term Life insurance coverage to provide life insurance coverage for their eligible dependent child(ren).
    - Each enrolled eligible child is covered for $20,000
  - You are the beneficiary
  - You pay the premium

All four types of term life insurance coverage offered under the Life Insurance Plan are covered by one group term life insurance policy (see the "General information" section on this page for more information).

Who's eligible

Basic Term Life and Optional Term Life for employees

Regular and fixed term Wells Fargo employees are eligible for Basic Term Life and Optional Term Life coverage under the Life Insurance Plan. Detailed eligibility requirements are described in the "Who's eligible to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

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 parents' Wells Fargo life insurance coverage elections.

The following are not eligible for Basic Term Life or Optional Term Life:

- Interns and flexible employees and their dependents
- Spouses and domestic partners
- Children

Spouse/Partner Term Life

Regular and fixed term employees are eligible to elect Spouse/Partner Term Life under the Life Insurance Plan to cover their eligible spouse or domestic partner. Detailed eligibility requirements are described in the "Who's eligible to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

An eligible spouse or domestic partner who is a Wells Fargo employee may be covered under Spouse/Partner Term Life and as an employee under their own Wells Fargo life insurance coverage election.

The following are not eligible for Spouse/Partner Optional Term Life:

- 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 spouse or domestic partner of a dependent child

Also read the "Active military duty exclusion" section on page 7-14.

Dependent Term Life

Regular and fixed term employees are eligible to elect Dependent Term Life under the Life Insurance Plan to cover their eligible dependent child or children. Detailed eligibility requirements are described in the "Who's eligible to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

An eligible dependent child who is a Wells Fargo employee may be covered under Dependent Term Life and as an employee under their own Wells Fargo life insurance coverage election.

The following are not eligible for Dependent Term Life:

- The child of an intern or flexible employee
- Your child who does not meet eligibility criteria, as defined in "Chapter 1: Eligibility, Enrollment, and More"
- A child's spouse or domestic partner

Also read the "Active military duty exclusion" section on page 7-14.

How to enroll and when coverage begins

Initial enrollment

Regular and fixed term employees are automatically enrolled in Basic Term Life coverage, no election is required.

Regular and fixed term employees 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. See the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the timeframe and process for enrollment as a new hire, rehire, or if you have an employment classification change and become eligible to enroll in benefits. **Note:** If your employment terminates and you are rehired within 30 days, any coverage you had at the time of termination will be reinstated at the same level as of your rehire date.

If you do not enroll during the designated initial enrollment period, you must follow the procedures described in the "Late enrollment" section on page 7-6.

- **Optional Term Life for employees**

  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 (see the "Covered pay" section on page 7-10 for more information).

  One to four times covered pay:

  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.

  Five to ten times covered pay:

  Enrollment for five to ten times your covered pay requires you to provide a completed Statement of Health form and is subject to MetLife's underwriting guidelines. For more information, see the "Statement of health" section on page 7-5.

- **Spouse/Partner Optional Term Life**

  You can enroll in coverage of $25,000 increments up to $250,000 for your spouse or domestic partner.

  $25,000 election:

  Enrollment at $25,000 (guaranteed issue amount) during your designated initial enrollment period does not require completion of the Statement of Health form.

  $50,000 to $250,000 election:

  Enrollment for coverage at $50,000 to $250,000 requires your spouse or domestic partner to provide a completed Statement of Health form and is subject to MetLife's underwriting guidelines. For more information, see the "Statement of health" section starting on page 7-5.

- **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 or canceling coverage" section starting on page 7-6), 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 the Dependent Life Insurance of more than one employee if both parents work for Wells Fargo.

  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. 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.

When coverage begins – initial enrollment

Basic Term Life begins on your hire date or the effective date of your classification change to regular or fixed term subject to the actively at work requirement as described in the "Delayed effective date" section on this page.

If you enroll in Optional Term Life coverage, Spouse/Partner Optional Term Life coverage, or Dependent Term Life coverage during the designated initial enrollment period, guaranteed issue coverage becomes effective on your hire date or the effective date of classification change to 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 this page.
- Spouse/Partner Optional Term Life coverage and Dependent Term Life coverage, with the exception of newborns, are subject to the actively at work requirement and the nonconfinement clause as described in the "Delayed effective date" section on this page.

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

General statement of health information

A statement of health application (also known as evidence of insurability) for Optional Term Life coverage (for employees) or Spouse/Partner Optional Term Life coverage is required for the following:

- Coverage amounts exceeding the guarantee issue amount, even at initial enrollment
- Late enrollment or increase in coverage requests of any amount
- 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 an evidence of insurability approval by MetLife.

The statement of health application ("application") you complete and submit to MetLife is a document with 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.

Statement of health process

1. First, you must make your election in Workday for one or more of the following:
   - Optional Term Life coverage (for employees)
   - Spouse/Partner Optional Term Life coverage

   If you are unable to make your election in Workday, call Employee Care for assistance (see the "Contacts" section on page 7-2).

Any amount requiring a statement of health application, will be pended and will not display as Calculated Coverage on your Workday Benefits page until after your coverage is approved by MetLife. See Step 2.

Note: If you complete and submit the required application before making your election in Workday (or calling Employee Care to make the election on your behalf) any approval by MetLife for increased coverage amounts will not be honored. If you are still interested in late enrollment or increasing your coverage, you can submit your election changes in Workday (or by calling Employee Care to make elections on your behalf) to start the application process over again, which will trigger a new statement of health for you to complete and submit for approval to MetLife. If the subsequent statement of health is approved, your coverage increase will be effective on the first of the month following MetLife's approval.

2. After your life insurance election is submitted in Workday (or by calling Employee Care), if evidence of insurability is required, you will receive a message in your Workday inbox with a link to the application that must be completed and submitted to MetLife for a determination. Separate applications are required for individual applicants.

   Important: You have 60 days from the date of your Workday inbox message to complete and submit the application. If the required application 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.

   Generally, the following timing applies for when you will receive the Workday inbox message:

   - Annual Benefits Enrollment: After your election is submitted in Workday and the Annual Benefits Enrollment period ends, you will receive a Workday Inbox message with a link to the application to be completed.
   - Initial enrollment, late enrollment, or increases at any time other than Annual Benefits Enrollment: After your election is submitted in Workday, you will receive a Workday Inbox message with a link to the application to be completed.

3. After you have completed and submitted the required application, MetLife will review the information and make a determination based on its underwriting guidelines and will notify Wells Fargo accordingly.

   - If MetLife approves the application, Wells Fargo will update your coverage amount in Workday. You can confirm your coverage at any time by viewing your Benefits Statement in Workday, which will display updated coverage amount after the effective date.
   - If Met Life does not approve the application, they will notify you.
     - Wells Fargo will also be notified, and your coverage amount will not change.

Coverage and premium effective dates

If MetLife approves the application, the updated coverage amount 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 7-5).
- For Spouse/Partner Optional Term Life coverage, the effective date of the coverage amount will be delayed if you're not actively at work and is also subject to the nonconfinement clause (see the "Delayed effective date" section on page 7-5).

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 or canceling coverage

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 (see the "Changing coverage due to a Qualified Event" section on page 7-7 for more information), you may enroll at any time, including Annual Benefit Enrollment, in Workday, provided you are actively at work. If you are 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.

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 7-5.

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.

Increasing coverage at any time

You may request an increase to your Optional Term Life or Spouse/Partner Optional Term Life coverage at any time, including Annual Benefit Enrollment, 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.

- See the "Statement of health" section on page 7-5 for more information.
- See the "Changing coverage due to a Qualified Event" section on this page for more information.

Decreasing or canceling coverage at any time

You may decrease or cancel your Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage at Annual Benefits Enrollment in Workday or any other time by contacting Employee Care. Coverage cannot be decreased or cancelled retroactively.

You must drop your dependent from coverage in Workday when they are no longer eligible. See the "You must drop ineligible dependents" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

Changing coverage due to a Qualified Event

You may be able to make a change to your life insurance elections if you experience one of the following Qualified Events:

- 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.
- Change in employment status for your spouse or domestic partner or 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).

If you experience one of the Qualified Events above, 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 "Dependent Term Life" bullet under the "How to enroll and when coverage begins" section:

- You may decrease or cancel your Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage.
  - You cannot make retroactive changes. See "When the change becomes effective" on this page for more information.
- Enroll in Optional Term Life coverage for the first time or increase your existing coverage by one times your covered pay, subject to the plan maximum (see the "Covered pay" section on page 7-10 for more information).
  - If you elect to enroll in or increase your Optional Term Life by more than one times your covered pay, you are required to complete the Statement of Health process. See the "Statement of health" section on page 7-5 for more information.
- Enroll in Spouse/Partner Optional Term Life coverage for the first time at a coverage target of $25,000 (or for birth, adoption, or placement for adoption, or increase existing Spouse/Partner Optional Term Life coverage by $25,000), subject to the plan maximum.
  - 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. **Note:** This does not apply if you have a domestic partner and then subsequently marry your domestic partner.
  - If you elect to enroll in or increase your Spouse/Partner Optional Term Life by more than the amount listed above, you are required to complete the Statement of Health process. See the "Statement of health" section on page 7-5 for more information.
  - 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.
- Enroll in Dependent Term Life coverage for the first time at a coverage target of $20,000 per child.

When the change becomes effective

All Annual Benefits Enrollment changes will be effective on the following January 1, subject to the actively at work requirement and the nonconfinement clause (see the "Delayed effective date" section on page 7-5). For mid-year changes, refer to the below information.

Optional Term Life (for employees)

For enrolling in or increasing 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 7-5 for more information).

If you were required to complete a Statement of Health form for coverage, see the See the "Statement of health" section on page 7-5 for the effective date.

For decreasing or canceling coverage

The effective date of the change will be the first of the month following the date you submitted your election change in Workday.

Spouse/Partner Optional Term Life

For enrolling in or increasing 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 7-5).

If you were required to complete a Statement of Health form for coverage, see the See the "Statement of health" section on page 7-5 for the effective date.

For decreasing or canceling coverage

The effective date of the change will be the first of the month following the date you submitted your election change in Workday, whichever is later.

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 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 7-5). 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 7-5).

For canceling coverage

The effective date of the change will be the first of the month following the date you submitted your election change in Workday.

Cost

Wells Fargo pays the 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, including any retroactive contributions or premium adjustments. 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, additional contributions, up to the extent permitted by applicable law, 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, or at its discretion, the plan administrator (or its delegate) may inform you of additional actions that may be taken by it to address your past due balance. If you are on a leave of absence, you may be billed directly.

The premium you pay for Dependent Term Life is a set amount regardless of the number of children covered.

The premium rate for Optional Term Life is calculated based on your coverage amount (which is calculated based on the coverage chosen), your age as of December 31 of the coverage period, and your and tobacco-user status, as applicable.

The premium rate for Spouse/Partner Optional Term Life is calculated based on the coverage chosen and your spouse/partner's age as of December 31 of the coverage period and your spouse's/partner's tobacco-user status, as applicable.

Premium rates for coverage for individuals who do not use any tobacco products are lower than the premium rates for tobacco users. Tobacco products include but are not limited to cigarettes, electronic cigarettes, cigars, pipes, and chewing tobacco.

If your or your spouse's or domestic partner's tobacco-user status changes after you enroll, you may change your or your spouse's or domestic partner's tobacco-user status at any time by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2. The change will be effective the first of the month following your call to Employee Care. Tobacco-user status cannot be changed retroactively.

For example, if you enroll as a tobacco nonuser but later begin to use tobacco products, you must change your status to tobacco user. Conversely, if you enroll as a tobacco user and stop using any tobacco products, you may change to tobacco-nonuser status. In either case, the new premium will be effective the first of the month following your call to Employee Care.

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 age of majority, 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 7-10.

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 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 in Workday or by accessing the Group Life and Disability Plans Beneficiary Designation Form on Teamworks at Home or Forms Online (this information cannot be taken over the phone). The change becomes effective on the date you make the change in Workday or upon Wells Fargo's receipt of the Group Life and Disability Plans Beneficiary Designation Form at the address on the form.

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:

4. Your surviving spouse or domestic partner[1]
5. Equally among your surviving biological and adopted children[2]
6. Equally between your surviving parents
7. Equally among your surviving brothers and sisters
8. 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 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.

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.

Life Insurance Plan benefits

Death benefit coverage amount

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 employees on a leave of absence and 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 last day worked. 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. Access Workday to determine your job class code (select Job Profile in Job Details section, page down to the Job Classifications section and click +More).

The life insurance benefit is based on your covered pay on the day before your death. (In a leave of absence or severance pay situation, your covered pay is frozen on your last date worked.) Access Workday to view your covered pay for Basic Term Life and Optional Term Life coverage. Select View Profile, then Actions, then Benefits, and then View Benefits Annual Rate to see your Life Covered Pay amount.

Job class code 2

If you are in job class code 2, your covered pay is determined as follows:

- If you are enrolling during Annual Benefits Enrollment for the next plan year, covered pay for the next plan year is determined using your annual base salary as of October 1 of the current plan year, plus any eligible incentive compensation paid by Wells Fargo in the 12 months prior to October 1 of the current plan year. Covered pay equals the greater of 1) the above stated earnings, or 2) a minimum of $10,000. **Once**

your covered pay is determined for a plan year, it will not change during that plan year even if your pay changes during the year.

- If you are on a leave of absence on January 1, your covered pay is the covered pay in effect on your last day worked and your newly calculated covered pay will not become effective until you return from leave of absence. Your newly calculated covered pay is determined using your annual base salary as of October 1 of the previous plan year, plus any eligible incentive compensation paid by Wells Fargo in the 12 months prior to October 1 of the previous plan year. Covered pay equals the greater of 1) the above stated earnings, or 2) a minimum of $10,000. **Once your newly calculated covered pay is determined when you return from your leave of absence, your covered pay will not change during that plan year even if your pay changes during the plan year.**
- If you are a newly hired, rehired, or newly eligible employee (including an employee who is an international transfer), your covered pay is based on salary and payroll information as of date of hire (or rehire or international transfer) or the date the employee becomes newly eligible, as applicable, and remains in effect for the remainder of the current plan year as long as employees continue to be eligible for benefits. Covered pay equals the greater of 1) the above stated earnings, or 2) a minimum of $10,000.

Annual base salary

Your annual or hourly* rate of pay (including geographical differentials, if applicable) 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

Eligible incentive compensation includes commissions, bonuses, and other earnings indicated in Workday as eligible incentive compensation.

Job class code 1 and 5

If you are in job class code 1 or 5, your covered pay is determined as follows:

- If you are enrolling during Annual Benefits Enrollment for the next plan year, covered pay for the next plan year is based on salary and payroll information on October 1 of the current plan year by annualizing base salary and incentives, incentive bonuses, and commissions paid in the 12 months prior to October 1 of the current plan year, or on a combination of these factors. Covered pay equals the greater of 1) annual salary, 2) the above stated earnings divided by the number of months with earnings greater than $0 and then annualized, or 3) a minimum of $20,000. Covered pay 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). **Once your covered pay is determined for a plan year, your covered pay will not change during that plan year even if your pay changes during the plan year.**
- If you are on a leave of absence on January 1, your covered pay is the covered pay in effect on your last day worked and your newly calculated covered pay will not become effective until you return from leave of absence. Your newly calculated covered pay is based on salary and payroll information on October 1 of the previous plan year by annualizing base salary and incentives, incentive bonuses, and commissions paid in the 12 months prior to October 1 of the previous plan year, or on a combination of these factors. Covered pay equals the greater of 1) annual salary, 2) the above stated earnings divided by the number of months with earnings greater than $0 and then annualized, or 3) a minimum of $20,000. Covered pay 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). **Once your newly calculated covered pay is determined when you return from your leave of absence, your covered pay will not change during that plan year even if your pay changes during the plan year.**
- If you are a newly hired, rehired, or newly eligible employee (including an employee who is an international transfer), your covered pay is determined by annualizing your earnings as of your hire (or rehire or international transfer) date or date you become newly eligible, as applicable, based on eligible incentive compensation paid to you by Wells Fargo in the prior 12 months, and remains the same throughout the year. Covered pay equals the greater of 1) annual salary, 2) the above stated earnings divided by the number of months with earnings greater than $0 and then annualized, or 3) a minimum of $20,000.
- Covered pay under the Life Insurance Plan may be calculated differently, by applying first-year minimum amounts, for certain job class code 5 positions as explained in the chart below. The first-year minimum covered pay will remain in place until the earlier of: (1) the Annual Benefits Enrollment following 12 months from your job start date or (2) the Annual Benefits Enrollment following your hire date if your calculation exceeds your first-year minimum covered pay amount. Once your covered pay exceeds your first-year minimum covered pay amount, then going forward, covered pay will be determined under the standard covered pay practice, even if your covered pay later falls below the first-year minimum covered pay amount.

Positions with first year minimum amounts	Job Code	Basic term life	Optional term life
Financial Consultant	101016	$50,000	$50,000
Financial Consultant (LO)	102310		
Lead Financial Advisory Consultant	130242		
Lead Financial Advisory Consultant (LO)	130245		
Associate Financial Advisor (LO)	103175	$50,000	$125,000
Bank Financial Advisor	103015		
Bank Financial Advisor (LO)	102289		
Lead Financial Advisory Management Trainee	101014		
Lead Financial Advisory Management Trainee (LO)	102308		
Private Client Financial Advisor	103019		
Private Client Financial Advisor (LO)	103018		
Profit Formula Financial Advisor	103023		
Profit Formula Financial Advisor (LO)	103022		
Financial Advisory Branch Manager - Producing	102270	$50,000	$200,000
Financial Advisory Branch Manager - Producing (LO)	102271		
Financial Advisory Senior Branch Manager - Producing	103465		
Financial Advisory Senior Branch Manager - Producing (LO)	103464		
Senior Bank Financial Advisor	101007		
Senior Bank Financial Advisor (LO)	102295		
Senior Private Client Financial Advisor	103017		
Senior Private Client Financial Advisor (LO)	103016		
Senior Profit Formula Financial Advisor	103027		
Senior Profit Formula Financial Advisor (LO)	103026		
Senior Wealth Client Financial Advisor	103201		
Senior Wealth Client Financial Advisor (LO)	103202		
Wealth Client Financial Advisor	103199		
Wealth Client Financial Advisor (LO)	103200		
Financial Advisory Branch Director - Producing (LO)	103534		
Financial Advisory Branch Director - Producing	103535		
Financial Advisory Branch Manager - Non-Producing	102440		
Financial Advisory Branch Manager - Non-Producing (LO)	102258		
Financial Advisory Senior Branch Manager - Non-Producing	103463		
Financial Advisory Senior Branch Manager - Non-Producing (LO)	103462		
Financial Advisory Branch Director - Non-Producing	103537		
Financial Advisory Branch Director - Non-Producing (LO)	103536		
Senior Bank Private Wealth Financial Advisor	103029	$50,000	$300,000
Senior Bank Private Wealth Financial Advisor (LO)	103028		
Senior Private Wealth Financial Advisor	103168		
Senior Private Wealth Financial Advisor (LO)	103167		

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, and not taken into account when determining if the amount payable exceeds the maximum benefit amount, 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 showing 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.

Active military duty exclusion

A spouse, domestic partner, or dependent child serving in the military of any country or international authority is not covered during active military duty. However, active military duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard.

A life insurance claim will be not paid if their death occurs while they are on active military duty regardless of the cause of death.

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 Support, 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 Support after receiving the initial communication mentioned above (Survivor Support will notify MetLife of the death after initial notification of the death).

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 beneficiaries, 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, 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 to have an authorized representative 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 policy. Decisions 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 "Life Insurance Plan claims and appeals" section starting on page 7-14 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. Wells Fargo continues to pay the premiums.
- If your Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage was already in effect on the date your approved leave of absence starts, coverage may continue as long as you continue to pay the premiums while on your approved leave. 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 you are required to complete the Statement of Health process (see the "Statement of health" section starting on page 7-5). 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."

When coverage ends

Coverage termination date

The applicable Life Insurance Plan coverage option ends on the last day of the month in which certain events occur, as shown below; however, if you or a covered dependent dies within 31 days of your coverage end date, your coverage still applies. You also 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: Other 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 this page 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 on the following page), 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 21 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 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. Under no circumstances will the option to port be extended past 91 days after the date your coverage ends.

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 you 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 you no longer meet the eligibility requirements.

Refer to the "When coverage ends" section on page 7-16 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 21 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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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: Other 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 BTA Plan and its underlying fully insured policy issued by Metropolitan Life Insurance Company ("MetLife") and the corresponding Certificate of Insurance ("certificate"). 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.

If you'd like a free copy of the certificate, you may contact Employee Care (see the"Contacts" section on page 8-2). **Note:** Individual certificates are not available.

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 whether benefits are payable under the BTA Plan.

BTA Plan highlights

Regular and fixed term Wells Fargo employees are automatically enrolled in BTA coverage to help provide financial protection if you are in a "covered accident" while you're traveling on work-related business resulting in your death or certain permanent impairment within 365 days of the date of the covered accident. See the "Covered accident" section starting on page 8-5 for the definition of a covered accident. See the "BTA Plan benefits" section starting on page 8-5 for more information on impairment conditions.

Wells Fargo pays the full cost of BTA Plan coverage.

Below is a listing of the types of benefits available when criteria are met:

- Death benefit (up to five times your covered pay, plan maximums apply)
- Felonious assault benefit
- Hospital stay benefit
- Seat belt and airbag benefit
- Wheelchair benefit
- Dismemberment, paralysis, brain damage, and coma benefits
- Exposure and disappearance coverage
- War risk coverage
- Terrorist act business travel coverage

See the "BTA Plan benefits" section starting on page 8-5 for detailed benefits and coverage information.

Who's eligible

Regular and fixed term Wells Fargo employees, as described in the "Who's eligible to enroll" section in "Chapter 1: Eligibility, Enrollment, and More", are eligible for the BTA Plan.

Interns and flexible employees are not eligible for coverage. Dependents are not eligible for coverage.

How to enroll and when coverage begins

If you meet the eligibility requirements, you are automatically enrolled under the BTA Plan on 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 are actively at work on that date. See the "Delayed effective date" section on this page for the definition of actively at work.

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. It does not include time away during the workday for personal reasons, any days off work, an observed holiday, or PTO.

Changing or canceling 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, known as a Minor on Deposit Account, until the child turns age of majority. 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.

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 or by accessing the Group Life and Disability Plans Beneficiary Designation Form on Forms Online or Teamworks at Home (this information cannot be taken over the phone). The change becomes effective on the date you make the change in Workday or upon Wells Fargo's receipt of the Group Life and Disability Plans Beneficiary Designation Form at the address on the form.

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.

Covered accident

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 for a business trip lasting less than 180 days
  - 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:
    - You are expected to remain in the new location to which you have traveled on business for more than 180 days
    - Wells Fargo deems a new location to be your regular place of work
  - 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.
  - 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.
- 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

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 "Covered accident" section on this page) 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. Access Workday to determine your job class code (select Job Profile in Job Details section, page down to the Job Classifications section and click +More).

The BTA benefit is based on your covered pay on the day before your covered accident or death. (In a leave of absence

or severance pay situation, your covered pay is frozen on your last date worked.) Access Workday to view your covered pay for Business Travel Accident coverage. Select View Profile, then Actions, then Benefits, and then View Benefits Annual Rate to see your BTA Covered Pay amount.

Job class code 2

If you are in job class code 2, your covered pay is determined as follows:

- Each year, covered pay for the next plan year is determined using your annual base salary as of October 1 of the current plan year, plus any eligible incentive compensation paid by Wells Fargo in the 12 months prior to October 1 of the current plan year. **Once your covered pay is determined for a plan year, it will not change during that plan year even if your pay changes during the year.**
- If you are on a leave of absence on January 1, your covered pay is the covered pay in effect on your last day worked and your newly calculated covered pay will not become effective until you return from leave of absence. Your newly calculated covered pay is determined using your annual base salary as of October 1 of the previous plan year, plus any eligible incentive compensation paid by Wells Fargo in the 12 months prior to October 1 of the previous plan year. **Once your newly calculated covered pay is determined when you return from your leave of absence, your covered pay will not change during that plan year even if your pay changes during the plan year.**
- If you are a newly hired, rehired, or newly eligible employee (including an employee who is an international transfer), your covered pay is based on salary and payroll information as of date of hire (or rehire or international transfer) or the date the employee becomes newly eligible, as applicable, and remains in effect for the remainder of the current plan year as long as employees continue to be eligible for benefits.

Annual base salary

Your annual or hourly* rate of pay (including geographical differentials, if applicable) 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

Eligible incentive compensation includes commissions, bonuses, and other earnings indicated in Workday as eligible incentive compensation.

Job class code 1 and 5

If you are in job class code 1 or 5, your covered pay is determined as follows:

- Each year, covered pay for the next plan year is based on salary and payroll information on October 1 of the current plan year by annualizing base salary and incentives, incentive bonuses, and commissions paid in the 12 months prior to October 1 of the current plan year, or on a combination of these factors. Covered pay equals the greater of 1) annual salary, or 2) the above stated earnings divided by the number of months with earnings greater than $0 and then annualized. Covered pay 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). **Once your covered pay is determined for a plan year, your covered pay will not change during that plan year even if your pay changes during the plan year.**
- If you are on a leave of absence on January 1, your covered pay is the covered pay in effect on your last day worked and your newly calculated covered pay will not become effective until you return from leave of absence. Your newly calculated covered pay is based on salary and payroll information on October 1 of the previous plan year by annualizing base salary and incentives, incentive bonuses, and commissions paid in the 12 months prior to October 1 of the previous plan year, or on a combination of these factors. Covered pay equals the greater of 1) annual salary, or 2) the above stated earnings divided by the number of months with earnings greater than $0 and then annualized. Covered pay 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). **Once your newly calculated covered pay is determined when you return from your leave of absence, your covered pay will not change during that plan year even if your pay changes during the plan year.**
- If you are a newly hired, rehired, or newly eligible employee (including an employee who is an international transfer), covered pay is determined by annualizing your earnings as of your hire (or rehire or international transfer) date or date you become newly eligible, as applicable, based on eligible incentive compensation paid to you by Wells Fargo in the prior 12 months, and remains the same throughout the year.

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 an additional benefit of 25% of the amount of coverage indicated in the"Death benefit amount" section on page 8-5 or the "Dismemberment, paralysis, brain damage, and coma benefits" section on page 8-8 up to a maximum plan benefit of $100,000, and will not be taken into account when determining the maximum plan benefit amount of $2,000,000,

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 additional 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 8-5 or the "Dismemberment, paralysis, brain damage, and coma benefits" section on page 8-8
- $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, and will not be taken into account when determining the maximum plan benefit amount of $2,000,000. 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 8-5 or the "Dismemberment, paralysis, brain damage, and coma benefits" section on page 8-8, not to exceed $50,000, but no less than $1,000, and not taken into account when determining if the amount payable exceeds the full amount, 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 8-5 or the "Dismemberment, paralysis, brain damage, and coma benefits" section on page 8-8, not to exceed $12,000, but no less than $1,000, and will not be taken into account when determining the maximum plan benefit amount of $2,000,000, 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 additional 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 8-5 or the "Dismemberment, paralysis, brain damage, and coma benefits" section on page 8-8 up to a maximum plan benefit of $50,000 and will not be taken into account when determining the maximum plan benefit amount of $2,000,000.

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 (see the "Covered accident" section on page 8-5) 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:

	Covered loss or injury	Amount paid
Dismemberment	Both hands or both feet or sight in both eyes; speech and hearing in both ears; or loss of any combination of hand, foot, or sight in one eye	100% of covered amount*
	One arm or leg	75% 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 arms and both legs (quadriplegia)	100% of covered amount*
	Both arms or both legs (paraplegia)	75% of covered amount*
	The arm and leg on either side of the body (hemiplegia)	50% of covered amount*
	One arm or leg (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, beginning on the 7th day of the coma, and continuing for 11 consecutive months, with the remaining balance paid as a lump sum in the 12th month)

* Covered amount is equal to 5 times covered pay not to exceed $2,000,000.

Covered losses or injury, total paralysis, brain damage, and coma are defined as follows:

- Loss of a hand permanently severed at or above the wrist but below the elbow or loss of a foot permanently severed at or above the ankle but below the knee.
- Loss of an arm permanently severed at or above the elbow or loss of a leg permanently severed at or above the knee.
- 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 the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.
- Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.
- Loss of a thumb and index finger of the same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.
- Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete, and irreversible.
- 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 state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 365 days of the accidental injury and continue for 7 consecutive days.

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 a covered accident 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, Turkey, Ukraine, 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, Turkey, Ukraine, 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 above any stated limitations or maximums.

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.

   MetLife Group Life Claims
   PO Box 6100
   Scranton, PA 18505-6100
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

You are not covered under the BTA Plan when you are not working because it only applies as described in the "Covered accident" section on page 8-5.

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: Other Notifications and Disclosures."

Conversion

You cannot convert the BTA Plan coverage to an individual policy.

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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: Other 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"). 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.

If you'd like a free copy of the certificate, you may contact Employee Care (see the "Contacts" section on page 9-2. **Note:** Individual certificates are not available.

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 whether benefits are payable under the AD&D Plan.

AD&D Plan highlights

Regular and fixed term employees are eligible to enroll in the AD&D Plan to help provide financial protection if you or your covered family member is in a "covered accident" resulting in death or certain permanent impairment within 365 days of the date of the covered accident. See the "Covered accident" section on page 9-6 for the definition of a covered accident. See the "AD&D Plan benefits" section starting on page 9-6 for more information on impairment conditions.

You may elect individual or family AD&D coverage. You may elect one the following coverage levels:

- $75,000
- $150,000
- $300,000
- $600,000

You pay the premiums for the cost of coverage you elect.

Below is a listing of the types of benefits available when criteria are met:

- Death benefit (based on your coverage level value)
- Felonious assault benefit
- Hospital stay benefit
- Seat belt and airbag benefit
- Home alteration and vehicle modification
- Rehabilitation benefit
- Therapeutic counseling
- Repatriation expense
- Spouse/Domestic partner education
- Child education benefits
- Child care center benefit
- Common accident benefit
- Dismemberment, paralysis, brain damage, and coma benefits
- Exposure and disappearance coverage
- War risk coverage
- Terrorism coverage

See the "AD&D Plan benefits" starting on page 9-6 for detailed benefits and coverage information.

Who's eligible

Regular and fixed term Wells Fargo employees are eligible to enroll in the AD&D Plan. If you enroll as an eligible employee, you may also cover your eligible dependents including your spouse or domestic partner. Detailed eligibility requirements are described in the "Who's eligible to enroll" section in "Chapter 1: Eligibility, Enrollment, and More."

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. **Note:** Also see the "Military duty exclusion" section on page 9-10.

Interns and flexible employees and their dependents are not eligible for the AD&D plan.

How to enroll and when coverage begins

See the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment as a new hire, rehire, or if you have an employment classification change and become eligible to enroll in benefits.

Eligible employees may elect individual or family AD&D coverage and select one of the following coverage levels:

- $75,000
- $150,000
- $300,000
- $600,000

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 from family to individual coverage or drop your coverage when you no longer have any eligible dependents. Otherwise, you will be paying for a benefit that you will not be able to use.

After you have enrolled, coverage will begin as described in the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More." Also see the "Delayed effective date" section on this page.

If you do not enroll in AD&D coverage for yourself or your eligible dependents when you are first eligible, you must wait until the next Annual Benefits Enrollment period to make an enrollment election. See the "Changing or canceling coverage" section on this page for more information.

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

Late enrollment

If you did not enroll in AD&D coverage during your designated enrollment period, you must wait until the next Annual Benefits Enrollment period to make an enrollment election. See the "Annual Benefits Enrollment" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

Increasing coverage

If you did not elect family coverage to cover your eligible dependents during your designated enrollment period, you must wait until the next Annual Benefits Enrollment period to increase your coverage to the family level. See the "Annual Benefits Enrollment" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

Decreasing or canceling coverage at any time

You may decrease or cancel your coverage at any time by submitting the change in Workday. Coverage cannot be canceled or changed retroactively.

You must change your coverage from family to individual coverage or drop your coverage when you no longer have any eligible dependents. See the "You must drop ineligible dependents" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

When the change becomes effective

If you elect, increase, decrease, or drop coverage during the Annual Benefits Enrollment period, your coverage change will become effective the following January 1, subject to the actively at work provisions described under the "Delayed effective date" section on this page.

If you elect to decrease or cancel your coverage at any time other than Annual Benefits Enrollment, the change will generally be effective the first of the month after the date your change is submitted in Workday.

Cost

You pay the full cost of premiums for your AD&D Plan coverage. Each pay period, you pay the premiums through after-tax payroll deductions. For more information on paying for coverage, see "Chapter 1: Eligibility, Enrollment, and More." 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.

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 or by accessing the Group Life and Disability Plans Beneficiary Designation Form on Forms Online or Teamworks at home (this information cannot be taken over the phone). The change becomes effective on the date you make the change in Workday or upon Wells Fargo's receipt of the Group Life and Disability Plans Beneficiary Designation Form at the address on the form.

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" 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.

Covered accident

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 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 is in a "covered accident" (as defined in the "Covered accident" section on this page), 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 9-10. Also see the "Military duty exclusion" section on page 9-10.

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 an additional 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 additional 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 an additional 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 additional 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.

If this benefit is in effect on the date of death and there is no spouse who could qualify for it, the AD&D plan will pay $1,000 to your beneficiary in one sum.

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 (see the "Covered accident" section on page 9-6) 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 loss of any combination of hand, foot, or sight in one eye	100% of covered amount*
	One arm or leg	75% 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 arms and both legs (quadriplegia)	100% of covered amount*
	Both arms or both legs (paraplegia)	75% of covered amount*
	The arm and leg on either side of the body (hemiplegia)	50% of covered amount*
	One arm or leg (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, beginning on the 7th day of the Coma, and continuing for 11 consecutive months, with the remaining balance paid as a lump sum in 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 permanently severed at or above the wrist but below the elbow or loss of a foot permanently severed at or above the ankle but below the knee.
- Loss of an arm permanently severed at or above the elbow or loss of a leg permanently severed at or above the knee.
- 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 the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.
- Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.
- Loss of a thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.
- Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete, and irreversible.
- 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 state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 365 days of the accidental injury and continue for 7 consecutive days.

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 a covered accident 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, Turkey, Ukraine, Yemen, and Zimbabwe.

Terrorism coverage

A terrorist act is considered a felony. Please refer to the "Felonious assault benefit" section on page 9-6.

Military duty exclusion

A spouse, domestic partner, or dependent child serving in the military of any country or international authority is not covered during active military duty. However, active military duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard.

An AD&D claim will be not paid if their death or medical condition otherwise covered under the plan is the result of a covered accident that occurs while they are on active military duty regardless of the cause.

What is not covered

The AD&D Plan will not pay benefits above any stated limitations or maximums.

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.

   MetLife Group Life Claims
   PO Box 6100
   Scranton, PA 18505-6100
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

Coverage while on a leave of absence

If your AD&D Plan coverage is already in effect on the date your approved leave of absence starts, coverage may continue as long as you continue to pay the premiums while on your approved leave. See "Appendix D: Leaves of Absence and Your Benefits" for more information.

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. See the "Late enrollment" section on page 9-4 for more information.

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."

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: Other 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 21 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 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. Under no circumstances will the option to port be extended past 91 days after the date your coverage ends.

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.

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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 Metropolitan Life Insurance Company (MetLife) 1-866-549-2320 metlife.com/mybenefits For the drop-down option, select Wells Fargo & Company
To fax documentation about your claim	MetLife 1-800-230-9531
Information about the Short-Term Disability Plan	HR Services & Support site MetLife 1-866-549-2320

The information in this chapter — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Other 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 SPD is a summary of provisions for the STD Plan. The STD Plan is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Claims administrator

The STD Plan is self-insured, and Metropolitan Life Insurance Company ("MetLife") is the claims administrator providing administrative claims services. MetLife has full discretionary authority to administer and interpret the STD Plan.

STD Plan highlights

The STD Plan provides you with short-term disability benefits (STD 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 10-7.) 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 10-10.) 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 STD 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.

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 or rehired employees

STD coverage begins on your date of hire or date of rehire to a regular or fixed term position, provided that you are actively at work on the day coverage is scheduled to begin.

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.

Employment classification changes

If you become eligible for STD coverage as a result of an employment classification change, your coverage becomes effective on the date of 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 this page)
- 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: Other 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 10-10.
- 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 a Medical Leave or Parental Leave

General information

The illustrations below and other information about leaves of absence in this section and the corresponding subsections are for informational purposes only and are not part of the STD plan or any other ERISA benefit sponsored by Wells Fargo, and do not provide the official requirements or information about Wells Fargo leave programs or policies. Review additional leave information on HR Services & Support.

The STD 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 and your STD claim is approved. Generally, you will be on a leave of absence that runs concurrently to your STD benefits.

A leave of absence is not part of the STD Plan and has different requirements, different forms to be completed, and different deadlines to submit required information. Review additional leave information on HR Services & Support.

How STD coordinates with a Medical Leave and FMLA

If you file a claim for STD benefits (other than maternity), generally, Medical Leave runs concurrently with STD benefits. You will be asked to submit specific forms and medical information to substantiate your Medical Leave. An approved medical leave ensures your manager is informed and your absences are properly documented. Different forms and more detailed information will be required to substantiate your claim for STD benefits. The table below shows generally how the time periods of Medical Leave, FMLA, and STD are coordinated when the applicable required documentation has been submitted and approved.

<table>
<tr><th>Week</th><th>Week 1</th><th>Weeks 2-12</th><th>Weeks 13-26</th></tr>
<tr><td rowspan="2">Leave type</td><td colspan="3">Medical Leave[1,2]</td></tr>
<tr><td colspan="2">FMLA up to 12 weeks if available[1,2]</td><td>N/A</td></tr>
<tr><td>STD benefits</td><td>STD waiting period
Use PTO, paid sick time, or unpaid time off</td><td colspan="2">STD benefits[1,3]</td></tr>
</table>

1. Different eligibility standards apply to Medical Leave, FMLA, and STD. See HR Services & Support for more information about Medical Leave and FMLA.
2. Medical leaves and FMLA are unpaid unless an STD claim is approved.
3. If the STD claim is approved, benefits are paid for the approved period, which is subject to change if required documentation is not provided or you do not abide by the terms of the plan.

How STD coordinates with a Parental Leave and FMLA

If you file a claim for maternity STD benefits, Parental Leave supplements the benefits you may be eligible to receive under the STD Plan if you meet the requirements for Parental Leave. You will be asked to submit specific forms and information to substantiate your Parental Leave request. Different forms and more detailed information will be required to substantiate your claim for STD benefits. Generally, Parental Leave runs concurrently with STD benefits. The tables below show generally how the time periods of Parental Leave, FMLA, and STD coordinate when the applicable required documentation has been submitted and approved. For more information about how the STD Plan coordinates with Parental Leave, see the "STD benefit amount" section on page 10-11.

Parental Leave – birth mother is the primary care giver (and eligible Wells Fargo employee)

<table>
<tr><th>Week</th><th>Week 1</th><th>Weeks 2-4</th><th>Weeks 5-8</th><th>Weeks 9-12</th><th>Weeks 13-16</th></tr>
<tr><td rowspan="2">Leave type</td><td colspan="4">Parental Leave – primary caregiver[1,2,3]</td></tr>
<tr><td colspan="4">FMLA up to 12 weeks if available[1]</td><td>N/A</td></tr>
<tr><td>STD benefits</td><td>STD waiting period[1]</td><td colspan="2">STD benefits weeks 2 through 5 or 2 through 7 (depending on delivery type)[1,2,4]</td><td>N/A</td><td>N/A</td></tr>
</table>

1. Different eligibility standards apply to Parental Leave, FMLA, and STD. See HR Services & Support for more information about Parental Leave and FMLA.
2. Parental Leave benefits are paid during the STD waiting period and supplement STD benefits to provide 100% of your Wells Fargo pay (minus required deductions) during the approved STD and applicable Parental Leave periods.
3. Parental Leave benefits are paid through Wells Fargo payroll up to the maximum 16-week period.
4. If the STD claim is approved, applicable benefits are paid for the approved period, which is subject to change if required documentation is not provided or you do not abide by the terms of the plan.

Parental Leave - birth mother is the non-primary care giver (and eligible Wells Fargo employee)

Week	Week 1	Weeks 2-4	Weeks 5-8	Weeks 9-12	Weeks 13-16
Leave type	Parental Leave – non primary caregiver[1,2,3]				
	FMLA up to 12 weeks if available[1]				N/A
STD benefits	STD waiting period[2]	STD benefits weeks 2 through 5 or 2 through 7 (depending on delivery type)[1,2,4]		N/A	N/A

1. Different eligibility standards apply to Parental Leave, FMLA, and STD. See HR Services & Support for more information about Parental Leave and FMLA.
2. Parental Leave benefits are paid during the STD waiting period and supplement STD benefits to provide 100% of your Wells Fargo pay (minus required deductions) during the approved STD and applicable Parental Leave periods.
3. Parental Leave benefits are paid through Wells Fargo payroll up to the maximum 4-week period.
4. If the STD claim is approved, applicable benefits are paid for the approved period, which is subject to change if required documentation is not provided or you do not abide by the terms of the plan.

How to file a claim for STD benefits

1. Call your manager

If you are unable to work your regular work schedule due to illness or injury, you must speak to your manager immediately. If you are unable to personally speak to your manager, have someone else make the call. You don't need to share any medical information with your manager, 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. Calling your manager is not filing a claim for STD benefits; you must file your STD claim separately (see #2 below).

If you are aware of an impending leave because of a planned medical procedure, you should provide your manager with at least 30 days advance notice.

Note: If your health condition is due to a work-related illness or injury, you must also call 1-877-HRWELLS (1-877-479-3557), option 2 to file a separate Workers' Compensation claim. Claims for STD benefits are reviewed independent of claims for Workers' Compensation benefits and you must file a claim for each separately. If you file both a Workers' Compensation claim and an STD claim and both are approved, the claims 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 10-11 for more information.)

2. File your claim for STD benefits

At the earliest, you may file your claim for STD benefits up to 30 days in advance of the date your leave is to begin. At the latest, you must file your claim for STD benefits within 90-days following your date of disability (the date of illness onset or injury that is the reason you are filing an STD claim).

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 MetLife. There are two ways to file your claim for STD benefits:

1. Call MetLife (see the "Contacts" section on page 10-2).
2. File online at metlife.com/mybenefits web portal. First-time users will need to establish a username and password by following the prompts on the screen. The organization is Wells Fargo & Company.

After you file your claim, your intake specialist will provide instructions to you if you wish to enroll to receive text alerts about your claim. You do not have to enroll in text alerts.

Note: If you are eligible for benefits under both the STD Plan and the STD Top-Up Plan (see the "STD Top-Up Plan" chapter), 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.

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 both of the following:

- Your manager
- MetLife (see the "Contacts" section on page 10-2)

For more information, see the "Recurrent condition" section on page 10-9.

3. Submit required authorizations

MetLife will require you to sign an authorization to obtain and release health information related to your disability claim. You'll want to complete this upon receipt of the request from MetLife.

The authorization allows MetLife to contact your health care provider to request additional information or clarifications about your health condition to process your STD claim or continue providing STD benefits. Your physician cannot share medical information about your disability unless the authorization is on file with MetLife. Failure to provide the required authorization may result in the denial of your claim for STD benefits.

Note: Your MetLife STD claim number and your first and last name must be on all correspondence provided to MetLife whether online or by mail.

4. Provide valid medical information by the due date

Proof of your disability is required for all disability claims and must be received by MetLife 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 MetLife deems necessary. **Note:** Your MetLife STD claim number and your first and last name must be on all correspondence provided to MetLife whether online or by mail.

MetLife may request medical information from your health care provider related to your STD claim; however, it is your responsibility to ensure the required information is timely submitted to MetLife. If the requested information is not submitted within the designated time frame, it may result in the denial of your claim for STD benefits or in having your previously approved STD benefit discontinued.

The medical information provided in support of your STD claim must be accurate. If the information is not accurate or the signature of the health care provider is not valid as determined by MetLife, your claim for STD benefits will be denied or your previously approved STD benefit discontinued, you will be disqualified from participating in the STD Plan, and you may be subject to further disciplinary action, including termination of employment.

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 "4. Provide valid medical information by the due date" on this page.
- 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 10-11 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 MetLife. 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 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 MetLife, 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 MetLife receives requested medical proof of your disability, which may include medical records, test results, and hospitalization records, within the designated time frame. If MetLife 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" section starting 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 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 MetLife was provided as soon as was reasonably possible.

Benefits determination

General determination information

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 MetLife
- 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 MetLife'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 10-14.

Denials

If MetLife 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 (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.) MetLife 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

MetLife 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. The individual managing your case at MetLife will monitor the payment of your STD benefits to ensure that your benefit is being processed correctly. It is your responsibility to keep MetLife and your manager 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 MetLife, unless your file is released to the plan administrator or its designee in connection with an appeal. MetLife 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 manager 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, as it pertains to your return to work, 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 manager 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 MetLife. Before you can return to work, MetLife and your manager 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

MetLife 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. MetLife 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

MetLife 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.

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 10-10).

If you are disabled and working (reduced work schedule)

A reduced work schedule is an accommodation provided to you by your manager, 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 manager, Accommodations Management, or both.

You will not receive more than 100% of pre-disability pay. Therefore, your 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 this page. 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 10-11). 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 this page). If you are making more than 80% of your earnings while on a reduced work schedule, your STD benefits will end.

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 this page.

- 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 this page.

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 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 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. Access Workday to determine your job class code (select

Job Profile in Job Details section, page down to the Job Classifications section and click +More). 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. If you are on a leave of absence, your covered pay is frozen on your last day worked.

Job class code 2

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

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).

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 10-10.

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 10-10.

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 MetLife (see the "Contacts" section on page 10-2).

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. If the state denies your state disability benefit, you must provide proof of your denial to MetLife. If you furnish proof of denial, your Wells Fargo STD benefits will not be reduced. However, if the state approves your claim on appeal, you are required to timely notify MetLife providing proof of the appeal decision and state benefit amount granted. Your Wells Fargo disability benefit will then be reduced accordingly. If you fail to timely provide documentation, you must re-pay any Wells Fargo STD benefits paid in error.
- 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.

MetLife will file for state benefits if you work in Colorado, Delaware, Hawaii, New Jersey, and New York on your behalf. However, If you work in a state or commonwealth with a mandatory disability program, it is your responsibility to apply for statutory benefits for most states.

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 MetLife 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 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 MetLife. For more information, see the "Medical evaluations and treatment plans" on page 10-9.
- 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 "Deductible sources of income" 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. If a minor child is named a beneficiary, benefits are generally not payable until the child turns 18. If a guardian of the child's estate or a conservator of the child's estate has been appointed by the court, the benefits can be paid to the child's estate. 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 or by accessing the Group Life and Disability Plans Beneficiary Designation Form on Forms Online (this information cannot be taken over the phone). The change becomes effective on the date you make the change in Workday or upon Wells Fargo's receipt of the Group Life and Disability Plans Beneficiary Designation Form at the address on the form.

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 10-13 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:
  - vi. You shared a single, intimate, committed relationship of mutual caring as of your date of death and intended to remain in the relationship indefinitely.
  - vii. You resided together in the same residence and lived in a spouse-like relationship prior to your date of death.
  - viii. 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.
  - ix. Neither of you was married to another person under either federal, state, or common law, and neither is a member of another domestic partnership.
  - x. You were both mentally competent to consent or contract.
  - xi. You were both at least 18 years old.
  - xii. 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
- War, declared or undeclared, or any act of war
- 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 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, MetLife 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, MetLife may have up to two additional extensions of 30 days each to provide you such notification.

If MetLife 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 MetLife's notice requesting additional information and an extension until MetLife receives the requested information does not count toward the time period that MetLife 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 MetLife.

Content of the claim determination notice

As noted in the "Claim determinations, determination extension, and requests for additional information" section on this page, 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 MetLife 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 MetLife 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 MetLife'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 MetLife. You or your duly authorized representative must sign your appeal request. It should be sent to MetLife by U.S. mail to the following address:

The MetLife Appeals
P.O. Box 14592
Lexington, KY 40512
Fax: 1-844-380-0569 or
Email: DisabilityAppeals@metlife.com

The address for filing an appeal is also noted in MetLife's adverse benefit determination letter.

Your appeal must be submitted in writing to MetLife 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, MetLife 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 MetLife. 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 MetLife 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 MetLife 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 MetLife. MetLife 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.

MetLife 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 MetLife for final consideration in the appeal review process (such information must be submitted before the final determination is due). MetLife 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 MetLife, 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 MetLife'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, MetLife may have up to an additional 45 days to provide you with notification of the final decision. If such an extension is needed, MetLife 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 MetLife.

If MetLife 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 MetLife 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 MetLife.

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 Metropolitan Life Insurance Company (MetLife) 1-866-549-2320 metlife.com/mybenefits For the drop-down option, select Wells Fargo & Company
To fax documentation about your claim	MetLife 1-800-230-9531
Information about the Short-Term Top-Up Disability Plan	HR Services & Support site MetLife 1-866-549-2320

The information in this booklet — along with applicable sections of "Chapter 1: Eligibility, Enrollment, and More," "Appendix B: Other 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

The SPD is a summary of provisions for the STD Top-Up Plan. The STD Top-Up Plan is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Claims administrator

The STD Top-Up Plan is self-insured, and Metropolitan Life Insurance Company (MetLife) is the claims administrator providing administrative claims services. MetLife has full discretionary authority to administer and interpret the STD Top-Up Plan.

STD Top-Up Plan highlights

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 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.

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 or rehired employees

For eligible employees, STD Top-Up Plan coverage begins on your date of hire or date of rehire to a regular or fixed term position, provided that you are actively at work on the day coverage is scheduled to begin.

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.

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 on the date of 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 this page)
- 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: Other 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 a Medical Leave or Parental Leave

General information

The illustrations below and other information about leaves of absence in this section and the corresponding subsections are for informational purposes only and are not part of the STD Top-Up plan or any other ERISA benefit sponsored by Wells Fargo, and do not provide the official requirements or information about Wells Fargo leave programs or policies. Review additional leave information on HR Services & Support.

The STD Top-Up Plan provides pay continuation above what may be allowed under the STD Plan 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 and your STD claim is approved (which is automatically coordinated with STD Top-Up benefits, you do not have to file a separate claim). Generally, you will be on a leave of absence that runs concurrently to your STD and STD Top-Up benefits.

A leave of absence is not part of the STD Top-Up Plan and has different requirements, different forms to be completed, and different deadlines to submit required information. Review additional leave information on HR Services & Support.

How STD Top-Up coordinates with a Medical Leave and FMLA

If you file a claim for STD benefits (other than maternity) resulting in STD Top-Up benefits, generally, Medical Leave runs concurrently with the STD and STD Top-Up benefits.

You will be asked to submit specific forms and medical information to substantiate your Medical Leave. Different forms and more detailed information will be required to substantiate your claim for STD benefits (no separate claim is filed for STD Top-Up benefits). The table below shows generally how the time periods of Medical Leave, FMLA, and STD/STD Top-Up are coordinated when the applicable required documentation has been submitted and approved.

<table>
<tr><th>Week</th><th>Week 1</th><th>Weeks 2-12</th><th>Weeks 13-26</th></tr>
<tr><td rowspan="2">Leave type</td><td colspan="2">Medical Leave[1,2]</td><td></td></tr>
<tr><td colspan="2">FMLA up to 12 weeks if available[1,2]</td><td>N/A</td></tr>
<tr><td>STD/STD Top-Up benefits</td><td>STD/STD Top-Up waiting period
Use PTO, paid sick time, or unpaid time off</td><td colspan="2">STD/STD Top-Up benefits[1,3]</td></tr>
</table>

1. Different eligibility standards apply to Medical Leave, FMLA, and STD/STD Top-Up. See HR Services & Support for more information about Medical Leave and FMLA.
2. Medical leaves and FMLA are unpaid unless an STD/STD Top-Up claim is approved.
3. If the STD/STD Top-Up claim is approved, benefits are paid for the approved period, which is subject to change if required documentation is not provided or you do not abide by the terms of the plan.

How STD/STD Top-Up coordinates with a Parental Leave and FMLA

If you file a claim for maternity STD benefits (and STD Top-Up benefits apply), Parental Leave supplements the benefits you may be eligible to receive under the STD Plan and STD Top-Up Plan if you meet the requirements for Parental Leave. You will be asked to submit specific forms and information to substantiate your Parental Leave request. Different forms and more detailed information will be required to substantiate your claim for STD benefits (no separate claim is filed for STD Top-Up benefits). Generally, Parental Leave runs concurrently with STD/STD Top-Up benefits. The tables below show generally how the time periods of Parental Leave, FMLA, and STD/STD Top-Up coordinate when the applicable required documentation has been submitted and approved. For more information about how the STD Top-Up Plan coordinates with Parental Leave, see the "STD Top-Up benefit amount" section on page 11-11.

Parental Leave – birth mother is the primary care giver (and eligible Wells Fargo employee)

Week	Week 1	Weeks 2-8	Weeks 9-12	Weeks 13-16
Leave type	Parental Leave – primary caregiver[1,2,3]			
	FMLA up to 12 weeks if available[1]			N/A
STD/STD Top-Up benefits	STD/STD Top-Up waiting period[1]	STD/STD Top-Up benefits weeks 2 through 5 or 2 through 7 (depending on delivery type) [1,2,4]	N/A	N/A

1. Different eligibility standards apply to Parental Leave, FMLA, and STD/STD Top-Up. See HR Services & Support for more information about Parental Leave and FMLA.
2. Parental Leave benefits are paid during the STD/STD Top-Up waiting period and supplement STD/STD Top-Up benefits to provide 100% of your Wells Fargo pay (minus required deductions) during the approved STD/STD Top-Up and applicable Parental Leave periods.
3. Parental Leave benefits are paid through Wells Fargo payroll up to the maximum 16-week period.
4. If the STD claim is approved and STD Top-Up benefits apply, STD Top-Up benefits are paid for the approved period, which is subject to change if required documentation is not provided or you do not abide by the terms of the plan.

Parental Leave - birth mother is the non-primary care giver (and eligible Wells Fargo employee)

Week	Week 1	Weeks 2-4	Weeks 5-8	Weeks 9-12	Weeks 13-16
Leave type	Parental Leave – non primary caregiver[1,2,3]				
	FMLA up to 12 weeks if available[1]				N/A
STD/STD Top-Up benefits	STD/STD Top-Up waiting period[2]	STD/STD Top-Up benefits weeks 2 through 5 or 2 through 7 (depending on delivery type) [1,2,4]		N/A	N/A

1. Different eligibility standards apply to Parental Leave, FMLA, and STD/STD Top-Up. See HR Services & Support for more information about Parental Leave and FMLA.
2. Parental Leave benefits are paid during the STD/STD Top-Up waiting period and supplement STD/STD Top-Up benefits to provide 100% of your Wells Fargo pay (minus required deductions) during the approved STD/STD Top-Up and applicable Parental Leave periods.
3. Parental Leave benefits are paid through Wells Fargo payroll up to the maximum 4-week period.
4. If the STD claim is approved, and STD Top-Up benefits apply, STD Top-Up benefits are paid for the approved period, which is subject to change if required documentation is not provided or you do not abide by the terms of the plan.

How to file a claim for STD benefits

1. Call your manager

If you are unable to work your regular work schedule due to illness or injury, you must speak to your manager immediately. If you are unable to personally speak to your manager, have someone else make the call. You don't need to share any medical information with your manager, 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. Calling your manager is not filing a claim for STD benefits; you must file your STD claim separately (see #2 below).

If you are aware of an impending leave because of a planned medical procedure, you should provide your manager with at least 30 days advance notice.

Note: If your health condition is due to a work-related illness or injury, you must also call 1-877-HRWELLS (1-877-479-3557), option 2 to file a separate Workers' Compensation claim. Claims for STD benefits are reviewed independent of claims for Workers' Compensation benefits and you must file a claim for each separately. If you file both a Workers' Compensation claim and an STD claim and both are approved, the claims 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 11-12 for more information.)

2. File your claim for STD benefits

At the earliest, you may file your claim for STD benefits up to 30 days in advance of the date your leave is to begin. At the latest, you must file your claim for STD benefits within 90-days following your date of disability (the date of illness onset or injury that is the reason you are filing an STD claim).

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 MetLife. There are two ways to file your claim for STD benefits:

1. Call MetLife (see the "Contacts" section on page 11-2).
2. File online at metlife.com/mybenefitsweb portal. First-time users will need to establish a username and password by following the prompts on the screen. The organization is Wells Fargo & Company.

After you file your claim, your intake specialist will provide instructions to you if you wish to enroll to receive text alerts about your claim. You do not have to enroll in text alerts.

Note: If you are eligible for benefits under both the STD Plan and the STD Top-Up Plan (see the "STD Top-Up Plan" chapter), 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.

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 both of the following:

- Your manager
- MetLife (see the "Contacts" section on page 11-2)

For more information, see the "Recurrent condition" section on page 11-10.

3. Submit required authorizations

MetLife will require you to sign an authorization to obtain and release health information related to your disability claim. You'll want to complete this upon receipt of the request from MetLife.

The authorization allows MetLife to contact your health care provider to request additional information or clarifications about your health condition to process your STD claim or continue providing STD benefits. Your physician cannot share medical information about your disability unless the authorization is on file with MetLife. Failure to provide the required authorization may result in the denial of your claim for STD benefits.

Note: Your MetLife STD claim number and your first and last name must be on all correspondence provided to MetLife whether online or by mail.

4. Provide valid medical information by the due date

Proof of your disability is required for all disability claims and must be received by MetLife 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 MetLife deems necessary. **Note:** Your MetLife STD claim number and your first and last name must be on all correspondence provided to MetLife whether online or by mail.

MetLife may request medical information from your health care provider related to your STD claim; however, it is your responsibility to ensure the required information is timely submitted to MetLife. If the requested information is not submitted within the designated time frame, it may result in the denial of your claim for STD benefits or in having your previously approved STD benefit discontinued.

The medical information provided in support of your STD claim must be accurate. If the information is not accurate or the signature of the health care provider is not valid as determined by MetLife, your claim for STD benefits will be denied or your previously approved STD benefit discontinued, you will be disqualified from participating in the STD Plan, and you may be subject to further disciplinary action, including termination of employment.

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 "4. Provide valid medical information by the due date" 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 MetLife. 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 MetLife, 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 MetLife receives requested medical proof of your disability, which may include medical records, test results, and hospitalization records, within the designated time frame. If MetLife 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 MetLife 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 MetLife
- 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 MetLife'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 11-15.

Denials

If MetLife 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 11-15.

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 (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.) MetLife 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

MetLife 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 MetLife 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 MetLife and your manager 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 MetLife, unless your file is released to the plan administrator or its designee in connection with an appeal. MetLife 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 manager 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, as it pertains to your return to work, 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 manager 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 MetLife. Before you can return to work, MetLife and your manager 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

MetLife 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. MetLife 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

MetLife 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.

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 manager, 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 manager, Accommodations Management, or both.

You will not receive more than 100% of pre-disability pay. Therefore, your 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 this page. 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. If you are making more than 80% of your earnings while on a reduced work schedule, your STD benefits will end.

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 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 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. Access Workday to determine your job class code (select Job Profile in Job Details section, page down to the Job Classifications section and click +More). 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. (If you are on a leave of absence, your covered pay is frozen on your last date worked.)

Job class code 2

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.

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 MetLife (see the "Contacts" section on page 11-2).

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. If the state denies your state disability benefit, you must provide proof of your denial to MetLife. If you furnish proof of denial, your Wells Fargo STD benefits will not be reduced. However, if the state approves your claim on appeal, you are required to timely notify MetLife providing proof of the appeal decision and state benefit amount granted. Your Wells Fargo disability benefit will then be reduced accordingly. If you fail to timely provide documentation, you must re-pay any Wells Fargo STD benefits paid in error.
- 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.

MetLife will file temporary disability benefits with Delaware, Colorado, Hawaii, New Jersey, and New York on your behalf. However, If you work in a state or commonwealth with a mandatory disability program, it is your responsibility to apply for statutory benefits for most states.

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 MetLife 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 MetLife. For more information, see the "Medical evaluations and treatment plans" section on page 11-9.
- 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. If a minor child is named a beneficiary, benefits are generally not payable until the child turns 18. If a guardian of the child's estate or a conservator of the child's estate has been appointed by the court, the benefits can be paid to the child's estate. 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 or by accessing the Group Life and Disability Plans Beneficiary Designation Form on Forms Online (this information cannot be taken over the phone). The change becomes effective on the date you make the change in Workday or upon Wells Fargo's receipt of the Group Life and Disability Plans Beneficiary Designation Form at the address on the form.

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 on page 11-14 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 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
- War, declared or undeclared, or any act of war
- 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

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, MetLife 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, MetLife may have up to two additional extensions of 30 days each to provide you such notification.

If MetLife 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 MetLife's notice requesting additional information and an extension until MetLife receives the requested information does not count toward the time period that MetLife 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 MetLife.

Content of the claim determination notice

As noted in the "Claim determinations, determination extension, and requests for additional information" section on this page, 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 MetLife 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 on this page.

Filing an appeal

If MetLife 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 MetLife'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 MetLife. You or your duly authorized representative must sign your appeal request.

It should be sent to MetLife by U.S. mail to the following address:

The MetLife Appeals
P.O. Box 14592
Lexington, KY 40512
Fax: 1-844-380-0569 or
Email: DisabilityAppeals@metlife.com

The address for filing an appeal is also noted in MetLife's adverse benefit determination letter.

Your appeal must be submitted in writing to MetLife 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, MetLife 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 MetLife. 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 MetLife 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 MetLife 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 MetLife. MetLife 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.

MetLife 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 MetLife for final consideration in the appeal review process (such information must be submitted before the final determination is due). MetLife 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 MetLife, 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 MetLife'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, MetLife may have up to an additional 45 days to provide you with notification of the final decision. If such an extension is needed, MetLife 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 MetLife.

If MetLife 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 MetLife 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 11-15 **for more information). Any suit for benefits must be brought within one year from the date the final appeal determination was issued by MetLife.**

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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	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320 metlife.com/mybenefits For the drop-down option, select Wells Fargo & Company
To fax documentation about your claim	MetLife 1-800-230-9531
Information about the Long-Term Disability (LTD) Plan	HR Services & Support site MetLife 1-866-549-2320 metlife.com/mybenefits For the drop-down option, select Wells Fargo & Company
Information about premiums for the LTD Plan	Check your enrollment materials, or go to the HR Services & Support site.
Information about employee enrollment, eligibility, or making coverage changes, or plan rates and comparisons	HR Services & Support site Employee Care Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2 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 B: Other Notifications and Disclosures," and "Appendix D: Leaves of Absence and Your Benefits" — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Long-Term Disability Plan (the LTD Plan).

The Basics

General information

The SPD is a summary of provisions for the LTD Plan. The SPD and Group Disability Income Policy issued by Metropolitan Life Insurance Company (MetLife), 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 along with any certificates, policy amendments, riders, and endorsements govern your right to benefits.

If you would like a free copy of the certificate, you may contact Employee Care (see the "Contacts" section on page 12-2). **Note:** Individual certificates are not available.

The LTD Plan is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Insurer and claims administrator

The LTD Plan is insured and administered by Metropolitan Life Insurance Company (MetLife). MetLife has the discretionary authority to administer claims and interpret benefits under the LTD Plan.

LTD Plan highlights

The LTD Plan offers two types of coverage and is designed to provide disability benefits for an eligible employee who is disabled for more than 26 weeks if MetLife approves your LTD claim.

- **Basic LTD coverage**
  - Regular and fixed term employees are automatically enrolled in Basic LTD coverage; no election is required.
  - Generally, Basic LTD coverage benefits replace 50% of your covered pay, referred to as "salary" in the Benefits section of Workday.
    - Up to a maximum monthly benefit amount of $20,833
  - Benefits payments will generally be taxable (consult a tax advisor).
  - Wells Fargo pays the premium.
- **Optional LTD coverage also known as Buy-Up coverage**
  - Regular and fixed term employees can elect Optional LTD coverage for themselves (dependents are not eligible).
  - Optional LTD coverage provides LTD benefits for an additional 15% of your covered pay.
    - Basic and Optional LTD together replace a combined total of up to 65% of your covered pay, up to a combined maximum monthly benefit amount of $27,083.
  - Optional LTD payments are generally not taxable.
  - You pay the premium for optional LTD coverage through after-tax payroll deductions each pay period.

LTD Plan benefits coordinate with (and will be reduced by) income replacement (and similar) payments that you may be entitled to or awarded. See the "LTD Plan benefits" section for more information.

Who's eligible

Basic LTD coverage

Regular and fixed term employees as described in the "Who's eligible to enroll" section of "Chapter 1: Eligibility, Enrollment, and More" are eligible for Basic LTD coverage.

Optional LTD coverage

Regular and fixed term employees as described in the "Who's eligible to enroll" section of "Chapter 1: Eligibility, Enrollment, and More" are eligible to enroll in Optional LTD coverage.

Ineligible individuals

The following individuals are not eligible to participate or enroll in the LTD Plan:

- An employee classified as a flexible employee or an intern
- An employee of a Wells Fargo affiliate not participating in the LTD Plan
- A person who 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" section)
- A person who Wells Fargo has classified as an international employee
- Dependents (spouse, domestic partner, children, step children, grandchildren, foster children, parents, grandparents, or other individuals)

How to enroll and when coverage begins

Initial enrollment

Basic LTD

You are automatically enrolled for Basic LTD coverage if you are one of the following:

- A newly hired (or rehired) regular or fixed term employee
- An employee who has had an employment classification change to a regular or fixed term position

Your coverage begins on your date of hire (or date of employment classification change to regular or fixed term position) provided that you are actively at work on the date coverage is scheduled to begin. If you are not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the day you resume active work. For more information about the actively at work requirement, see the "Delayed effective date" section on page 12-6.

Note: 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 LTD coverage under the LTD Plan when you first become an employee as a result of the acquisition or merger.

Optional LTD

If you want to enroll in Optional LTD coverage, see the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the timeframe and process for enrollment as a new hire, rehire or newly eligible employee. Also note the following:

- **New hires or newly eligible employees (newly eligible due to employment classification change)**
  - For regular and fixed term employees, Optional LTD coverage, if elected during your designated enrollment period — begins on your date of hire (or date of employment classification change to regular or fixed term position) provided that you are actively at work on the date coverage is scheduled to begin.*
  - In general, the premium you pay is effective on the date your coverage is effective. For more information on cost, see the "Cost and premiums" section on page 12-6.
- **Rehired employees**
  - If you are rehired into a regular or fixed term position within the six-month period following your Wells Fargo termination date, your Optional LTD coverage will be reinstated on your rehire date at the same level (enrolled or not enrolled) that was in effect on your termination date. You must be actively at work on the date coverage is scheduled to begin.*
  - If you are rehired into a regular or fixed term position after the six-month period following your Wells Fargo termination date, Optional LTD coverage, if elected during your designated enrollment period — begins on your rehire date if you are actively at work on the date coverage is scheduled to begin.*
  - In general, the premium you pay is effective on the date your coverage is effective. For more information on cost, see the "Cost and premiums" section on page 12-6.

* For more information about the actively at work requirement, see the "Delayed effective date" section on page 12-6.

If you do not enroll during your initial designated enrollment period, you will have to wait until you have one of the allowed Qualified Events or the Annual Benefits Enrollment period, or you may request late enrollment at any time, as described in the sections below.

Note: 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 LTD coverage and Optional LTD coverage under the LTD Plan when you first become an employee as a result of the acquisition or merger.

Enrolling due to a Qualified Event

If you did not enroll in Optional LTD coverage during your initial designated enrollment period, you may elect to enroll in Optional LTD coverage during the year by submitting your election in Workday within 60 days of the date one of the following Qualified Events occurs (you are not required to provide evidence of insurability to MetLife if you want to enroll due to one of these Qualified Events):

- 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
- Your return from an unpaid leave of absence taken by you

You must make your election change in Workday within 60 days of the date of the event listed above. 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, within the allowed 60-day timeframe to make your election changes.

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

If you make a change to your optional LTD coverage within the permitted 60-day period as a result of a Qualified Event listed above:

- A preexisting condition exclusion may apply to your Optional LTD coverage if you enroll due to a Qualified Event (see the certificate for more information).
- Most changes in coverage will be effective the later of the first of the month following the date of the event or the first of the month following the date you submit your election

change in Workday, or you call Employee Care. However, you must be actively at work on the day your coverage is effective. For more information about the actively at work requirement, see the "Delayed effective date" section on page 12-6.

- In general, the change in premium you pay is effective on the date your change in coverage is effective. Premium rates can change when your age and covered pay change, and your payroll deductions will be adjusted accordingly.

Annual Benefits Enrollment

If you did not enroll in Optional LTD coverage during your initial designated enrollment period or within 60-days of a Qualified Event, you may enroll in Optional LTD during Annual Benefits Enrollment.

- A preexisting condition exclusion may apply to your Optional LTD coverage if you enroll during Annual Benefits Enrollment (see the certificate for more information).
- Coverage will be effective January 1 of the year following the Annual Benefits Enrollment period in which you made your Annual Benefits Enrollment election. However, you must be actively at work on the date your coverage is effective. If you are not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the day you resume active work. For more information about the actively at work requirement, see the "Delayed effective date" section on page 12-6.
- In general, the premium you pay is required on the date your coverage takes effect on January 1.

Late enrollment

If you did not enroll in Optional LTD coverage during your initial designated enrollment period, at Annual Benefits Enrollment, or you missed your 60-day window for enrolling as a result of a Qualified Event, you may request enrollment at any point during the year by providing a statement of health application (also known as evidence of insurability) to MetLife.

The statement of health application ("application") you complete and submit to MetLife is a document with a series of questions about your overall health and is used by MetLife to determine if the applicant meets MetLife's insurability guidelines, based on their underwriting rules.

For more information about requesting late enrollment, the statement of health application, and the coverage effective date for late enrollment, see the "Statement of health" section on this page.

Statement of health

Statement of health process

1. First, you must make your election in Workday for Optional LTD coverage.

   If you are unable to make your election in Workday, call Employee Care for assistance (see the "Contacts" section on page 12-2).

   If your enrollment election requires the statement of health process, your enrollment will be pended and will not show on your Workday Benefits page until after your coverage is approved by MetLife. See Step 2.

   Note: If you complete and submit the required application before making your election in Workday (or calling Employee Care to make the election on your behalf) any approval by MetLife for Optional LTD coverage will not be honored. If you are still interested in late enrollment, you can submit your election changes in Workday (or by calling Employee Care to make elections on your behalf) to start the application process over again which will trigger a new statement of health for you to complete and submit for approval to MetLife. If the subsequent statement of health is approved, your Optional LTD coverage will be effective on the first of the month following MetLife's approval.

2. After your Optional LTD coverage election is submitted in Workday (or by calling Employee Care), if evidence of insurability is required, you will receive a message in your Workday inbox with a link to the application that must be completed and submitted to MetLife for a determination.

   Important: You have 60 days from the date of your Workday inbox message to complete and submit the application. If the required application 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 to enroll.

3. After you have completed and submitted the required application, MetLife will review the information and make a determination (approve or deny) the application based on its underwriting guidelines and will notify Wells Fargo accordingly.

   - If MetLife approves the application, Wells Fargo will update your election in Workday. You can confirm your coverage at any time by viewing your Benefits Statement in Workday, which will display after the effective date.
   - If Met Life does not approve the application, they will notify you.
     - Wells Fargo will also be notified, and you will not be enrolled in Optional LTD coverage.

Coverage and premium effective dates

If MetLife approves the application, your enrollment in Optional LTD coverage will become effective on the first day of the month following the date MetLife approves the application, subject to the following:

- A preexisting condition exclusion may apply to your Optional LTD coverage if MetLife approves your request for late enrollment (see the certificate for more information).
- You must be actively at work on the date coverage is scheduled to begin. For more information about the actively at work requirement, see the "Delayed effective date" section on this page.

The associated premium deductions will be reflected in your paycheck that includes the pay period covering the effective date of your enrollment.

Employment classification changes

If your employment classification is changed to a regular or fixed term employee and you become newly eligible for benefits, see the "Initial enrollment" section on page 12-4.

If you change employment classification from regular or fixed term to flexible or intern, your Basic LTD coverage and Optional LTD coverage (if applicable) will end as of the employment classification change date. If you are receiving LTD benefits for an approved claim as of your employment 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.

Cancelling your coverage

You cannot cancel your Basic LTD coverage.

As an after-tax benefit, you may cancel your Optional LTD coverage at any time by submitting the change in Workday; go to Change Benefits and selecting Voluntary Drop After Tax Benefits. Your coverage ends at the end of the period for which you paid your last premium. Premiums are not refunded.

Delayed effective date

If you are not actively at work on the date coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full work day in a regular or fixed term position.

"Actively at work" means you are performing your customary duties during your regularly scheduled hours as a regular or fixed term employee 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.

Cost and premiums

Basic LTD

Wells Fargo pays the full cost of premiums for your Basic LTD coverage.

Optional LTD

If you choose to enroll for Optional LTD coverage, you are responsible for paying 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. When your age changes or if your covered pay changes, your premium will be adjusted accordingly.

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. If you don't continue paying your premiums during the LTD waiting period and until your claim for LTD benefits is approved, your Optional LTD coverage will terminate.

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.

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.

Rules for pre-existing conditions

In determining whether a disability is due to a pre-existing condition, MetLife will credit you for any time you were insured under the prior plan. If your disability is due to a pre-existing condition as described in this certificate, but would not have been due to a pre-existing condition under the prior plan, MetLife will pay a benefit equal to the lesser of:

- the benefit amount under this certificate
- the disability income insurance benefit that would have been payable to you under the prior plan
- If your disability would have been due to a pre-existing condition under the prior plan, it will be treated as having been caused by a pre-existing condition under this certificate

LTD Plan benefits

General information

Benefit payments are subject to all of the conditions, maximums, limitations, exclusions, proof requirements, definitions, and terminology stated in the Group Policy insurance documents (as described in the "General information" section under "The Basics" on page 12-3). Refer to your MetLife certificate of coverage (certificate) for the following information and other details and requirements:

- Definitions, including but not limited to:
  - Appropriate care and treatment
  - Beneficiary
  - Disability
  - Domestic partners
  - Elimination or waiting period
  - Local economy
  - Normal retirement age
  - Own occupation
  - Pre-disability earnings
- Benefits
  - Benefit amount
  - Elimination or waiting period
  - Benefit minimums and maximums
  - Reductions to your benefits
  - Mental health- or chemical dependency-related disability benefits
  - Rehabilitation program
  - Family care incentive
- Providing proof of your disability
- Limits and exclusions
- When benefit payments end
- Lien and repayment
- Overpayments

To qualify for LTD benefits, you must:

- Be covered by the LTD Plan on the initial date of your disability
- Have satisfied the LTD waiting period (as defined by the LTD Plan, generally be disabled 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
- File an LTD claim with MetLife under the LTD Plan
- Submit all required information as determined and requested by MetLife
- Receive approval for LTD benefits by MetLife
- Receive appropriate care and treatment by a doctor on a continuous basis prior to and while receiving LTD benefits
- Any other requirements set forth in the MetLife LTD group policy or certificate of coverage

For additional details, see the certificate.

If MetLife approves your claim under the LTD Plan, benefits will be paid monthly following completion of your LTD waiting period. For approved claims, LTD benefits will begin to accrue on the date following the day you complete the LTD waiting period. LTD benefits will be paid on a monthly basis thereafter as long as you continue to be considered disabled, as determined by MetLife, up to the maximum benefit period. Your benefits may end before the stated maximum benefit period; for additional details, see the certificate.

Your approved LTD benefit payment will be sent to your home address unless you request that your payment be deposited directly in your bank account.

Maximum long-term disability benefit period if you are disabled when you are	Maximum benefit period
Under 60	Your maximum LTD benefit period is the greater of your normal retirement age as defined by the Social Security Administration or age 65 (but not less than 5 years).
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

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. Access Workday to determine your job class code (select Job Profile in Job Details section, page down to the Job Classifications section and click +More). 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

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.

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

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. 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).

Benefit amount

MetLife will calculate disability benefits for an approved claim. The benefit amount is based on your covered pay (referred to as "salary" in the Benefits section of Workday) on the day before your date of disability minus any deductible sources of income. Generally, covered pay is converted from an annual amount (not exceeding $500,000 per year) to a monthly amount. In addition, LTD benefit payments are based on the number of days you are disabled during each one-month period. To view your LTD covered pay, log into Workday and go to View Profile, then choose Actions, then choose Benefits, and then view Benefits Annual Rate. You will see your LTD Covered Pay under Benefits Annual Rate.

If you have satisfied the LTD waiting period and MetLife approves your LTD claim, generally the plan provides the following:

- 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 up to $20,833 per month, minus deductible sources of other income as determined by MetLife.
- If you are enrolled for Optional LTD coverage, it 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 up to $27,083 per month, minus deductible sources of other income, as determined by MetLife.
- The minimum monthly LTD benefit is 10% of your gross LTD benefit or $100, whichever is greater, minus deductible sources of other income as determined by MetLife. 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).

Various other forms of income will be deducted from your LTD benefit before payment is made, such as but not limited to the following (see the certificate for more information):

- Social Security benefits (including disability, retirement, and dependents' benefits but excluding survivor benefits)
- Earnings from any type of employment
  - See the certificate for more information about programs associated with the LTD Plan that allow you to work or transition back to work while you are disabled
- Workers' Compensation benefits, including a settlement awarded to you
- Automobile or other accident wage replacement income or settlement awarded to you
- Benefits from any state or public employee retirement or disability plan
- Railroad Retirement Act benefits
- Statutory benefits, including state disability benefits

- Any other group plan providing total disability benefits sponsored by or contributed to by Wells Fargo
- Third-party recovery for loss of income by judgment, settlement, or otherwise, including recovery amounts you may receive from future earnings
- Benefits awarded under unemployment insurance laws or programs

You must provide information requested by MetLife about any deductible sources of income within 10 business days from the date of the award. If this information is not provided within the required timeframe, it may result in an overpayment of benefits for which you will be required to repay the LTD Plan. For more information, see the "Lien and Repayment" section on page 12-10.

Taxation of LTD benefits

Basic LTD benefits are considered taxable income. You may contact MetLife to ask that federal and state taxes be withheld from your LTD benefits; see the "Contacts" section on page 12-2.

If you do not have taxes withheld from your LTD benefits, or if the amount withheld is not enough to cover your actual taxes due, you may be required to pay additional taxes. Consult a tax advisor for tax information related to your LTD benefits.

Note: Optional LTD benefits are generally not taxable income because Optional LTD premiums are paid with after-tax dollars. Consult a tax advisor for tax information related to your LTD benefits.

Single Sum Payment in the event of your death

You do not designate a beneficiary for LTD benefits. However, if you die while receiving LTD benefits for an approved claim, the LTD Plan will pay your eligible survivor a lump sum in an amount equal to five times your net monthly LTD benefit. **Note:** MetLife will first reduce the survivor benefit by any overpayment that may exist on your LTD claim.

In order for a survivor lump sum benefit to be paid, 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 MetLife.
- Any other requirements set forth in the MetLife LTD group policy or certificate of coverage.

For more information, see the certificate.

LTD Plan claims and appeals

See the "Claims" section of the certificate for claims filing information. To view the certificate, visit metlife.com/mybenefits (access using the instructions in the "Contacts" section of this chapter). If you would like a free copy of the certificate, you may contact Employee Care (see the "Contacts" section on page 12-2). **Note:** Individual certificates are not available.

Generally, 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 MetLife for filing an LTD claim. If you have been disabled for 18 weeks or more and you have not received instructions from MetLife, call MetLife (see the "Contacts" section of this chapter). If you delay in filing your LTD claim, claim approval and any applicable benefit payments may also be delayed causing a gap in income for you. If you are enrolled in the LTD Plan, you agree to authorize your provider to give MetLife information about your diagnosis and treatment 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.

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 Section 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 LTD 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 LTD Plan, any and all questions arising from:

- Administration of the LTD Plan claims and interpretation of all provisions of the LTD 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 LTD 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 LTD 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 (access using the instructions in the "Contacts" section on page 12-2).

Lien and Repayment

Lien

MetLife will be subrogated to all rights of recovery that you have against a third party, subject to the provisions stated in the policy or certificate. See the certificate for more information.

This does not limit MetLife's right to repayment from another source which may otherwise exist under law.

If You become disabled and you receive disability benefits under this certificate and you receive payment from a third party for loss of income with respect to the same loss of income for which you received benefits under this certificate (for example, a judgment, settlement, payment from Federal Social Security, or payment pursuant to Workers' Compensation laws), You shall reimburse us from the proceeds of such payment up to an amount equal to the benefits paid to you under this certificate for such disability. MetLife's right to receive reimbursement from any such proceeds shall be a claim or lien against such proceeds and MetLife's right shall provide them with a first priority claim or lien over any such proceeds up to the full amount of the benefits paid to you under this certificate for such disability. You agree to take all action necessary to enable MetLife to exercise their rights under this provision, including, without limitation:

- Notifying MetLife as soon as possible of any payment you receive or are entitled to receive from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate
- Furnishing of documents and other information as requested by MetLife or any person working on MetLife's behalf
- Holding in escrow, or causing your legal representative to hold in escrow, any proceeds paid to you or any party by a third party for loss of income with respect to the same loss of income for which you received benefits under this certificate, up to an amount equal to the benefits paid to you under this certificate for such disability, to be paid immediately to MetLife upon your receipt of said proceeds

You shall cooperate and you shall cause your legal representative to cooperate with MetLife in any recovery efforts and you shall not interfere with their rights under this provision. MetLife's rights under this provision apply whether or not you have been or will be fully compensated by a third party for any disability for which you received or are entitled to receive benefits under this certificate.

Repayment

MetLife may recover the overpayment from you by:

- Stopping or reducing any future disability benefits, including the minimum benefit, payable to you or any other payee under the disability sections of this certificate
- Demanding an immediate refund of the overpayment from you
- Taking legal action.

If the overpayment results from MetLife having made a payment to you that should have been made under another group plan, MetLife may recover such overpayment from one or more of the following:

- Any other insurance company
- Any other organization
- Any person to or for whom payment was made

See the certificate for more information.

Limitations for particular conditions

Mental illness

If you are disabled by a mental illness (see the definition of "Mental illness" in the certificate), the LTD Plan generally pays a maximum of 24 monthly LTD benefit payments in your lifetime unless you are disabled due to Neurocognitive disorders:

- Schizophrenia
- Alzheimer's disease and other forms of dementia
- Organic brain disease
- Bipolar I 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" in the certificate.

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 certificate. 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 if you are disabled when you are" table on page 12-7)
- 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 MetLife 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

LTD coverage continues for certain leaves of absence types

Eligibility for Basic LTD and Optional 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

Basic LTD

While on one of the above leave types, Basic LTD coverage will continue as long as you continue to satisfy the eligibility requirements of the LTD Plan.

Optional LTD

If you are enrolled in Optional LTD coverage when your leave begins for one above leave types, you must continue to pay the monthly premiums to remain enrolled during your leave. For more information, see "Appendix D: Leaves of Absence and Your Benefits" section.

Note: You must continue to pay the monthly premiums during the LTD waiting period and until your claim for LTD benefits is approved.

LTD coverage ends for certain leaves of absence types

Eligibility for Basic and Optional LTD coverage ends when certain types of leaves of absence begin. This means that if you become disabled during one of the leave types below, you will not be eligible to file a claim for LTD benefits. However, 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 certificate for more information).

- Personal Leave
- Job Search Leave
- Preferential Hiring Leave
- Unpaid Administrative Leave
- Military Leave
- Job-Protected Unpaid Leave

Returning to work after an approved leave of absence

Basic LTD

If you return to work in a regular or fixed term position immediately after your approved Medical Leave, Workers' Compensation Leave, Family Leave, Paid Administrative Leave, Parental Leave, Critical Caregiving Leave, or Job Protected Paid Leave ends, your Basic LTD coverage continues on the date you return to work provided you are actively at work on that date. See the "Delayed effective date" section on page 12-6 for more information.

If you return to work in a regular or fixed term position on the first business day after your approved Personal Leave, Job Search Leave, Preferential Hiring Leave, Unpaid Administrative Leave, Military Leave, or Job-Protected Unpaid Leave ends, your Basic LTD coverage will be reinstated. Coverage is effective on the date you return to work provided you are actively at work on the date coverage is scheduled to begin. See the "Delayed effective date" section on page 12-6 for more information.

Optional LTD

- **Employees returning to work within 6 months or less from the first day of an approved leave of absence.**
  - If you continued to pay your Optional LTD premiums while on an approved Medical Leave, Workers' Compensation Leave, Family Leave, Paid Administrative Leave, Parental Leave, Critical Caregiving Leave, or Job Protected Paid Leave, and you return to work in a regular or fixed term position on the first business day after your leave ends, your Optional LTD coverage will continue, and your monthly premium deductions will resume. If you don't want your coverage to continue 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.
  - If you discontinued paying the required premiums during your approved Medical Leave, Workers' Compensation Leave, Family Leave, Paid Administrative Leave, Parental Leave, Critical Caregiving Leave, or Job Protected Paid Leave, and you return to work in a regular or fixed term position after your leave, you will have to re-enroll in Optional LTD coverage and you'll be subject to a pre-existing condition exclusion. See the "Enrolling due to a Qualified Event" section on page 12-4, the "Annual Benefits Enrollment" section on page 12-5, and the "Late enrollment" section on page 12-5 for more information.
  - If you return to work in a regular or fixed term position on the first business day after your approved Personal Leave, Job Search Leave, Preferential Hiring Leave, Unpaid Administrative Leave, Military Leave, or Job-Protected Unpaid Leave ends, your Optional LTD coverage is reinstated upon your return. You will not be subject to a new LTD preexisting condition exclusion. Your Optional LTD coverage will be effective on the date you return to work provided you are actively at work on the date coverage is scheduled to begin (see the "Delayed effective date" section on page 12-6 for more information). **Note:** 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.
  - If you return to work in a regular or fixed term position after your leave ends and you did not have Optional LTD coverage before your leave began, you may request enrollment after your return to work. See the "Enrolling due to a Qualified Event" section on page 12-4, the "Annual Benefits Enrollment" section on page 12-5, and the "Late enrollment" section on page 12-5 for more information.
- **Employees returning to work after six months from the first day of an approved leave of absence**
  - If you continued to pay your Optional LTD premiums while on an approved Medical Leave, Workers' Compensation Leave, Family Leave, Paid Administrative Leave, Parental Leave, Critical Caregiving Leave, or Job Protected Paid Leave, and you return to work in a regular or fixed term position on the first business day after your leave ends, your Optional LTD coverage will continue, and your monthly premium deductions will resume. If you don't want your coverage to continue 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 but no later than 60 days from your return.
  - If you discontinued paying the required premiums during your approved Medical Leave, Workers' Compensation Leave, Family Leave, Paid Administrative Leave, Parental Leave, Critical Caregiving Leave, or Job Protected Paid Leave, and you return to work in a regular or fixed term position after your leave, you will have to re-enroll in Optional LTD coverage. See the "Enrolling due to a Qualified Event" section on page 12-4, the "Annual Benefits Enrollment" section on page 12-5, and the "Late enrollment" section on page 12-5 for more information.
  - If you return to work in a regular or fixed term position on the first business day after your approved Personal Leave, Job Search Leave, Preferential Hiring Leave, Unpaid Administrative Leave, Military Leave, or Job-Protected Unpaid Leave ends, your Optional LTD coverage is not automatically reinstated, even if you had Optional LTD coverage on the date before your approved leave began. However, you can re-enroll in Optional LTD coverage in Workday within 60 days from the date you return to work. In Workday, go to "Change Benefits" and select "Insurance Election Changes." If you re-enroll within the 60-day timeframe, your Optional LTD coverage will be effective on the date you return to work provided you are actively at work on the date coverage is scheduled to begin (see the "Delayed effective date" section on page 12-6 for more information). **Note:** If you miss your 60-day enrollment window, to re-enroll at another time, see the "Enrolling due to a Qualified Event" section on page 12-4, the "Annual Benefits Enrollment" section on page 12-5, and the "Late enrollment" section on page 12-5 for more information.

- If you return to work after six months from the first day of a Military leave, regardless of whether you were enrolled in Optional LTD before your 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 as long as you are actively at work on the day your coverage is effective.
- If you return to work in a regular or fixed term position after your leave ends and you did not have Optional LTD coverage before your leave began, you may request enrollment after your return to work. See the "Enrolling due to a Qualified Event" section on page 12-4, the "Annual Benefits Enrollment" section on page 12-5, and the "Late enrollment" section on page 12-5 for more information.

Coverage for terminated employees who are receiving Wells Fargo severance pay

Basic LTD

When you are eligible to receive severance benefits under Wells Fargo & Company Severance Plan, your employment with Wells Fargo terminates and enrollment in and coverage for Basic LTD coverage ends.

If you are rehired by Wells Fargo to work in a regular or fixed term position, Basic LTD coverage will begin again; see the "Initial enrollment" section on page 12-4.

Optional LTD

When you are eligible to receive severance benefits under the Wells Fargo & Company Severance Plan, your employment with Wells Fargo terminates and enrollment in and coverage for Optional LTD coverage ends.

If you are rehired by Wells Fargo in a regular or fixed term position, if you want Optional LTD coverage, you must re-enroll; see the "Initial enrollment" section on page 12-4.

When coverage ends

Your eligibility to be enrolled for Basic and Optional LTD coverage ends on the earliest of the following dates:

- The day your last day of employment takes place[1]
- The day you no longer meet the eligibility requirements[1]
- The day you transfer to an ineligible employment classification or position[1]
- The day you begin a Military Leave, Job Search Leave, Preferential Hiring Leave, unpaid Administrative Leave, Job-Protected Unpaid Leave, or Personal Leave[1]
- The day you stop paying for Optional LTD coverage (Optional LTD only)[1]
- The first of the month following the day you request to drop your Optional LTD coverage (Optional LTD only)[1]
- The date you are eligible for benefits under the Wells Fargo & Company Severance Plan[1]
- The day you die[1]
- The day Wells Fargo terminates the LTD Plan or the applicable coverage option under the LTD Plan[1,2]

1. 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.
2. 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: Other Notifications and Disclosures."

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Chapter 13: Legal Services Plan

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Contacts

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: Other 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

General Information

The SPD is a summary of provisions for the Legal Services Plan and its underlying fully insured policy issued by ARAG. The SPD and Certificate Number C16862, along with any applicable policies, policy amendments, riders, and endorsements (collectively the "Group Plan") constitute the official plan document for the Legal Services Plan. If there are differences between the SPD and the certificate, the certificate governs your rights to benefits.

To get a copy of Certificate Number C16862, email ARAG at: service@ARAGlegal.com.

The Wells Fargo Legal Services Plan is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

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. Wells Fargo is the plan administrator and has retained all other authority not delegated to ARAG herein.

Legal Services Plan 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 a network attorney and provide educational resources to assist you with your covered legal matter.
- **Legal representation and telephone advice from ARAG network attorneys** for personal legal issues. Network attorney fees for covered benefits are 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®, Attorney Finder, identity theft resources, and a Learning Center.
- **The option to retain an attorney of your choice outside of the ARAG network and receive reimbursement for a portion of the fees for covered services**. Submit a claim form and receive reimbursement for attorney fees paid up to the benefit amount indicated in the Legal Services Plan (refer to the "Covered services" section starting on page 13-5). 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 $195 cost for each year's tax preparation. Tax preparation includes federal tax return, state tax return, local tax return, and any additional tax preparation needs. The rate is subject to change.

See the "How the Legal Services Plan works" section starting on page 13-4 and the "Covered services" starting on page 13-5 for more detailed benefits and coverage information. You must be enrolled in the plan on the date of service to receive benefits.

Who's eligible

Regular and fixed term Wells Fargo employees are eligible to enroll in the Legal Services Plan. If you enroll as an eligible employee, you may also cover your eligible dependents including your spouse or domestic partner. 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 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.

Interns and flexible employees and their dependents are not eligible for the Legal Services Plan.

How to enroll and when coverage begins

See the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment as a new hire, rehire, or if you have an employment classification change and become eligible to enroll in benefits.

You may elect individual or family coverage. Enrollment in family Legal Services coverage provides coverage for all eligible dependents. You do not need to separately enroll each individual dependent.

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

If you did not enroll when first eligible or you want to make changes to or cancel your enrollment elections, you may do so 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."

You must drop your dependent from coverage in Workday when they are no longer eligible. See the "You must drop ineligible dependents" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

Cost

Employees pay the full cost for coverage. All contributions collected from employees electing this coverage are paid to ARAG. 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.

For information about paying for your coverage, see the "Cost and funding" section in "Chapter 1: Eligibility, Enrollment, and More."

How the Legal Services Plan works

General information

After enrollment, you will receive a new member welcome email, which includes a welcome message, your member ID number, and link to the member portal. If you're not working (for example, you're on an approved leave of absence), please contact ARAG at 800-299-2345 and they will mail you a printed member kit to your address on file.

You must be enrolled in the Legal Services Plan on the date you receive legal services to be eligible for applicable benefits.

There are four ways to use the Legal Services Plan:

1. Work with a network attorney virtually, over the phone or in person
2. Connect with a telephone network attorney for legal advice and document prep/review.
3. Use online tools and resources to manage and learn more about legal matters.
4. Legal advice and representation from non-network attorneys

When you need help with a legal matter, you can start a case online by logging into ARAGlegal.com/account or the ARAG Legal app. If you need help or have questions, call ARAG Customer Care at 1-800-299-2345 or email service@ARAGlegal.com. Your coverage will be confirmed before you receive a list of local network attorneys to help you handle your case.

An ARAG Customer Care specialist may assist in providing the following:

- Information about your plan and how your plan's coverage may apply to your case
- Your CaseAssist® confirmation, which includes details about your case and a list of local network attorneys who can help with next steps
- Access to a telephone network attorney who can give you quick and comprehensive legal advice, even if you do not have an open or pending legal case
- Next steps and resources to help you deal with your personal legal matter, including guidebooks and articles found in the Learning Center

Confidentiality and ethics

Your use of the Plan and the legal services is confidential. Wells Fargo will know nothing about your legal issues or the services you use under the Plan. All attorneys' services provided under the Plan are subject to ethical rules established by the courts for lawyers. The attorneys' obligations and relationship is exclusively with you. The Plan has no liability for the conduct of any Plan attorneys. You have the right to file a complaint with the applicable state bar concerning attorney conduct pursuant to services performed under the Plan. You have the right to retain at your own expense any attorney authorized to practice law in the applicable state outside of the Plan.

Online tools and resources

Start using your online legal resources with the ARAG Learning Center. To get started, go to www.ARAGlegal.com/myinfo (access code = 16862wfc). You will need to create a personal user name and password the first time you log in.

As a participant in the Legal Services Plan, you have access to the following:

- Identity Theft Protection to monitor your sensitive information across the web and alert you when your information is found in places you'd rather it not be (for more information, see the "Consultation and resource services" table starting on page 13-6).
- Caregiving resources, including services for parents and grandparents, and access to databases to research eldercare options (for more information, see the "Consultation and resource services" table starting on page 13-6).

- Online member portal to start a case, confirm coverage, and look for an attorney
- Online network attorney profiles that include years of experience on the network, areas of law practiced, and ratings and reviews from other members
- DIY Docs, an online resource that allows you to create legally valid state-specific documents

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 service 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 13-5 for more information.

Network access

As a participant in the Legal Services Plan, you are guaranteed access to a network attorney. 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 by a network attorney over the telephone. Members can be connected to a network telephone attorney who is licensed in the member's state. When a member has a quick question regarding a personal legal matter, a telephone attorney is available to provide general legal advice, review and prepare documents, and identify potential options for next steps.

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 telephone network attorney over the phone, contact ARAG directly at 1-800-299-2345 from 9:00 a.m. to 5:00 p.m. local time. When you contact ARAG's Customer Care Center, you will need to enter your unique member identification number shown on your identification card. You may speak with a telephone network attorney as often as necessary, at no additional cost to you.

Local network

For matters within the jurisdiction of the United States, you can meet with a local network attorney over the phone, virtually, 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. Bring your CaseAssist® confirmation when you go to meet with an attorney. If you work with a network attorney on a covered matter, you do not need to file a claim for reimbursement; the network attorney does it for you.

Legal service from non-network attorneys

You also have the option to choose 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 legal services" table starting on page 13-8. After your office visit, simply notify ARAG within 60 days of your visit and file a claim form along with your attorney's invoice and proof of payment within 180 days after full payment is made for your legal services (refer to the "Claims for benefits" section starting on page 13-20). 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 the type of service and whether or not you use an attorney in ARAG's network as described in the subsections below:

- "Consultation and resource services" starting on page 13-6
- "Covered legal services" starting on page 13-8
- "Reduced fee services" on page 13-19
- "Reduced contingency fee services" on page 13-19

Consultation and resource services

Certain online and telephone consultation services with a network attorney are generally provided at no cost. Also see the "Telephone network" section on page 13-5 for more information about telephone consultations.

If more extensive services or additional legal advice or representation is needed, costs may apply, at the discretion of ARAG or the network attorney.

Service Type	Services provided
General advice (phone consultation only)	Members can call a telephone network attorney and receive the following services: • General legal advice on how the law relates to your personal legal matter and which action may be taken • Follow-up correspondence and telephone calls to third parties related to your personal legal matter • Specific document preparation and document review • The preparation or review of a standard will or codicils
Caregiving resources To assist you in finding adult and senior care, access the digital educational and support tools or connect with a care coach. To get started, go to www.ARAGlegal.com/myinfo (access code = 16862wfc). You will need to create a personal user name and password the first time you log in.	Members have access to various caregiving resources: • **Access personalized content and resources** Members answer a few simple questions to get information and resources to help with informed caregiving decisions based on their needs. • **Work with a coach** Care coaches can help members understand and identify the care options for their loved ones, including in-home care, nursing home and assisted living, confirming availability, providing assistance with the application process, validating licensure and certifications, and identifying pricing, costs, and payment obligations. • **Plan and manage care** Members can use the mobile landing page and app to - Create and share caregiver support plans, upload and track important legal documents, providers, medications, and coordinate with the care team - Get support, resources, and guidance on topics like chronic diseases, mental health, home and facility-based care, financial needs, and end-of-life planning. • **Caregiving Guidebook:** Members have access to a guidebook that provides tools and resources for your caregiving role. Members also have access to other online tools and resources to assist with their caregiving needs, including: • DIY Docs®: On behalf of their parents/grandparents, employees can create legally valid documents using this interactive tool. • Reduced fee legal services for parents/grandparents: Should they need legal representation, members' parents/grandparents can use a network attorney at a reduced rate of at least 25% off the network attorney's normal rate. Network attorneys will bill the parent/grandparent directly. This service is not guaranteed and is based on availability of a network attorney in their area.
Immigration consultation (phone consultation only)	Toll-free access to a telephone network attorney for: • Legal advice and consultation • Immigration processes and guidelines • Filing and processing of applications and petitions • Information about 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

Service Type	Services provided
Identify theft protection Certain services require that you register online with ARAG at www.ARAGlegal.com/myinfo (access code = 16862wfc). You will need to create a personal user name and password the first time you log in. **Note:** The employee's parents and grandparents (up to four) are also eligible for the above "Identity theft protection" services. Enrollment in identity theft monitoring services through ARAG is required for coverage of these services.	An ARAG service that gives you access to: • Toll-free legal advice from a telephone network attorney to assist with legal-related problems that the theft of your identity may have caused. • Identity Theft Materials, including: - An Identity Theft Prevention Kit to help protect yourself from becoming a victim of identity theft in the first place, - An Identity Theft Victim Action Kit to help speed your recovery should you become an identity theft victim, - A tracking document to help you keep track of phone calls, emails and letters for attorneys, - An Identity Theft Affidavit to help you report your identity theft to necessary parties. - Identity theft specialists who will help you determine appropriate steps to begin recovery and help you monitor the progress of your recovery. • Certified identity theft restoration specialists who provide - Full-service identity restoration services, including specialized limited Power of Attorney to work on your behalf to restore your identity. - Assisting with canceling and reissuing personal documents such as credit cards, driver's license, Social Security Cards, etc. — due to a lost or stolen wallet or identity documents. • Identity theft insurance: If you become a victim of identity theft, identity theft insurance provides coverage up to $1 million for expenses and cash recovery associated with restoring your identity. (The identity theft insurance is underwritten by American Bankers Insurance Company of Florida, an Assurant company. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Please see the plan summary document for details.) • In order to use the following services, you will need to log in and establish an online monitoring account. - Single-bureau credit monitoring: Services designated to track and immediately inform you of any activities or changes to your credit — including loan applications, credit card activations, delinquencies, etc. - Internet surveillance: Services that monitor thousands of websites and millions of online data points and will alert you if your personal information is being traded and/or sold. - Change of address: Services that monitor address change requests with the United States Postal Services. - Child monitoring includes: ◦ Services that enable parents or guardians to protect a minor's information from identity theft by registering and tracking their data. ◦ Social Security Number trace monitoring which will detect the creation of a credit file in a minor's name.
Tax services	You have year-round access to an experienced tax specialist. You can call toll-free for a one-on-one consultation if you have questions or need advice regarding your personal, non-business related tax matters for the following: • Tips for state or federal filing of personal taxes • Explanation of tax law changes • Research on complex tax matters • Advice regarding IRS audits and notifications • Review of last year's personal tax return • Discounted personal tax return preparation You may also use an ARAG tax specialist to prepare your personal federal, state, and local tax returns at a cost of $195 for each tax return prepared. The rate per tax return is subject to change.

Covered legal services

Service	Network attorney	Non-network attorney
Immigration services Any representation-based 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
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.	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[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
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[2]
• Trial starting on day four (4) until completion	Paid in full	$100,000[3]
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]
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]

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
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]
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]

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 – 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]
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]
Homeowner Association Disputes Legal services for an insured as a plaintiff or defendant regarding written, verbal or implied contracts or obligations related to your homeowner association.	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
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.		
• 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.		
• 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]
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]

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) 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]
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]
• Durable and/or 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]

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
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 hours)	$720[1]
Prenuptial agreement Legal services for an insured for the preparation of a prenuptial or antenuptial agreement.	Paid in full	$320[1]
Postnuptial agreements Legal services for the named insured for the preparation of a postnuptial agreement.	Paid in full	$320[1]
Domestic partnership agreements Legal services for an insured for the preparation of a domestic partnership.	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.)		
• Alimony	Paid in full	$400[1]
• Child custody/child visitation	Paid in full	$960[1]
• Child support	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.)		
• Alimony	Paid in full	$400[1]
• Child custody/child visitation	Paid in full	$960[1]
Child support enforcement Legal services for an insured for a motion brought by you or against 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.)	Paid in full	$640[1]
School administrative hearing Legal services for an insured in an administrative public or private formal school proceeding regarding disabilities, and accompanying educational accommodations and/or 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 or felony charges) 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 (Legal Services as it relates to post-judgment garnishment is covered for this benefit.)	Paid in full	$100,000[3]
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
Surrogacy agreement Legal services for an insured for the preparation of a surrogacy agreement.	Paid in full	$300[1]
Pre-birth/post-birth parentage order Legal services for an insured for the preparation of a pre-birth and post-birth parentage order.	Paid in full	$320[1]
Egg/sperm/embryo donation agreement Legal services for an insured for the preparation of an egg, sperm, or embryo donation agreement.	Paid in full	$480[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
Elder law – member support		
• Initial advice for an insured on the impact of your parent's/ grandparent's legal matter on you.	Paid in full	$25
• Legal services for an insured for the preparation and review of a deed granted by a parent/grandparent where you are the grantee.	Paid in full	$40 per document
• Legal services for an insured for the preparation and review of a promissory note where your parent/grandparent is the payor and you are the payee.	Paid in full	$40 per document
• Legal services for an insured for the review of your parent's/ grandparent's personal legal documents, including estate planning documents where you have been named as an agent or executor/personal representative.	Paid in full	$40 per document
Annual legal check-up for parents Legal services for the insured's parents to meet with an attorney on an annual basis. This annual meeting is to discuss the legal needs of the insured's parents and to discuss any changes in their situation and potential legal implications. This service is limited to one use per certificate year.	Paid in full	$80[1]
Advice for parents Telephone access to obtain legal advice and consultation on how the law relates to your parent's legal matters and which action may be taken.	Paid in full	No coverage
Document preparation for parents Legal services for your parents for the preparation of deeds, mortgages, promissory notes, affidavits, lease contracts, demand letters, installment contracts, bills of sale, HIPAA authorization and certification of trust.	Paid in full	$40 per document
Document review for parents Legal services for the review of your parents' personal legal documents.	Paid in full	$40 per document
Wills and durable power of attorney for parents Preparation of the documents listed below for your parents. This benefit is limited to two uses per certificate year. Completion of spousal documents is considered one use.		
• Individual will or spousal will(s). (Does not include any tax planning service done in connection with the will.)	Paid in full	$320 single document $400 spousal documents
• Codicil (an amendment to a will)	Paid in full	$40 single document $80 spousal documents
• Living will/health care directive	Paid in full	$40 single document $80 spousal documents
• Durable/financial power of attorney	Paid in full	$40 single document $80 spousal documents

1. Non-network attorney Indemnity Benefits are up to the stated amount.

Reduced fee services

If your legal matter is not fully covered under the group policy and is not listed under the "Plan exclusions and limitations" section on page 13-19, you are eligible to work with a network attorney and receive a reduced fee that will be at least 25% off the attorney's normal rate (discounts and rates are subject to change). The initial consultation for each legal matter will be provided at no cost. If you retained the services of the network attorney prior to the effective date of coverage under the plan, the reduced fee benefit is not available. Payment of attorney fees is handled directly between the plan member and the network attorney. Access to a network attorney is subject to availability. You are encouraged to contact ARAG to determine proximity to a network attorney within legal practice areas.

For matters that include a cap on the number of hours ARAG will pay a network attorney, and where your legal matter will exceed the amount covered by ARAG, the network attorney will bill you directly at reduced rates of at least 25% off their normal rate (discounts and rates are subject to change). You pay the attorney directly. For telephone advice, if your matter cannot be resolved over the phone and is not fully covered under the group policy and not excluded under the "Plan exclusions and limitations" section on page 13-19, you are eligible to work with a network attorney and receive a reduced fee that will be at least 25% off the attorney's normal rate. Payment of attorney fees is handled directly between the plan member and the network attorney.

Reduced contingency fee services

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, at their discretion. 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 trial, or will not exceed 33% of the net recovery if successfully resolved during or after trial, or will not exceed 40% 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 coverage under the plan, the reduced contingency fee benefit is not available.

Plan exclusions and limitations

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 legal matters where you wish to take action against a party, regardless of whether the matter proceeds to you filing a lawsuit against the other party, 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 legal services" table starting on page 13-8

If you have a question about coverage for a specified service, please contact ARAG directly.

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 or canceling coverage" on page 13-4 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 a covered 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: Other Notifications and Disclosures."

Continuing your coverage directly with the carrier

Conversion is a provision which gives you the option to convert your current coverage to an individual policy if group coverage terminates for any reason other than failure to pay the required premium. ARAG will send enrolled employees a personalized communication about continuation of coverage within 31 days of the date your coverage ends (the 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 (the 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 a claim form with an itemized attorney invoice and proof of payment within 180 days of completion of the covered 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, your authorized representative, 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 claimant will be notified in writing of the reasons for the delay and the date by which a final decision can be expected. The claimant will be informed about the delay before the initial 90 days have passed.

If ARAG denies all or part of your claim, you, your authorized representative, 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, your authorized representative, or your beneficiary. 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).

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 outlined above. For more information, see the "Enrollment and eligibility disputes" section in "Chapter 1: Enrollment, Eligibility, and More."

Authorized Representative

An individual with respect to whom a covered individual has authorized, in accordance with ARAG's policies and procedures, to file claims and appeals on behalf of the individual.

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 on page 13-20. 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

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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 • From work: No sign on or registration required. Go to HR Services & Support, select HR Tools, and click MetLife My Benefits. • From home: Go to metlife.com/mybenefits and follow the instructions to set up your online MetLife account (enter Wells Fargo for "Employer").
Questions about claims or appeals or to get a printed copy of the applicable certificate	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: Other 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

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 coverage effective date, you can view your state-specific certificate as instructed in the following paragraph. 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 through the MetLife MyBenefits site (access using the instructions in the "Contacts" section on page 14-2). If you would like a free printed copy of the state-specific certificate for your state of residence, call MetLife (see the "Contacts" section on page 14-2).

Before your effective date, you can also 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.

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.

Critical Illness Insurance Plan highlights

The Critical Illness Insurance Plan offers two types of coverage:

- **Basic Critical Illness coverage**
  - Regular and fixed term employees are automatically enrolled in Basic Critical Illness coverage; no election required
    - You cannot enroll your dependents in basic coverage
  - Benefit of up to $5,000 maximum per covered condition
  - $25,000 lifetime maximum benefits per covered person
  - Benefit payments may be taxable (Wells Fargo does not provide tax advice)
  - Wells Fargo pays the premium
- **Optional Critical Illness coverage**
  - Regular and fixed term employees can elect optional coverage for themselves and their eligible dependents
    - You have to enroll yourself in order to cover eligible dependents
  - Benefits up to $15,000 maximum per covered condition
  - $75,000 lifetime maximum benefits per covered person
  - You pay the premiums

See the "Critical Illness Insurance Plan benefits" section on page 14-6 and the certificate on the MetLife site (access using the instructions in the "Contacts" section on page 14-2) for details about benefits and coverage. You, or your eligible dependent, must be enrolled in the Critical Illness Insurance Plan on the date of diagnosis to receive benefits.

The Critical Illness Insurance Plan is not medical coverage and should not be considered a replacement for enrolling in medical coverage.

Who's eligible

Basic Critical Illness Insurance coverage

Regular and fixed term Wells Fargo employees as described in the "Who's eligible to enroll" section of "Chapter 1: Eligibility, Enrollment, and More" are automatically enrolled in Basic Critical Illness Insurance coverage.

Interns and flexible employees are not eligible for Basic Critical Illness Insurance coverage.

Dependents (spouse, domestic partner, and dependent children) are not eligible for Basic Critical Illness Insurance coverage.

Optional Critical Illness Insurance coverage

Regular and fixed term Wells Fargo employees are eligible to enroll in Optional Critical Illness Insurance coverage. If you enroll as an eligible employee, you may also cover your eligible dependents including your spouse or domestic partner.

However, the following are not eligible for Optional Critical Illness Insurance coverage:

- Interns and their dependents
- Flexible employees and their dependents
- Dependents who do not meet Wells Fargo dependent eligibility criteria
- You if you are enrolled in Optional Critical Illness Insurance coverage as a dependent of another Wells Fargo employee
- Your dependent who is enrolled in Optional Critical Illness Insurance coverage as an employee or a dependent of another Wells Fargo employee
- An unborn or stillborn child

Detailed eligibility requirements are described in the "Who's eligible to enroll" section of "Chapter 1: Eligibility, Enrollment, and More."

Additional dependent 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 (access using the instructions in the "Contacts" section on page 14-2).

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.

How to enroll and when coverage begins

Eligible employees are automatically enrolled in Basic Critical Illness insurance coverage.

For enrolling in optional coverage, see the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment as a new hire, rehire, or if you have an employment classification change and become eligible to enroll in benefits.

Eligible employees may elect one of the following:

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

After you have enrolled, coverage will begin as described in the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More." Also see the "Delayed effective date" section on this page.

If you do not enroll or elect coverage for your eligible dependents when you are first eligible, you must wait until the next Annual Benefits Enrollment period to make an enrollment election. See the "Changing or canceling coverage" section starting on this page for information.

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

Late enrollment

If you did not enroll in Optional Critical Illness Insurance during your initial designated enrollment period or at Annual Benefits Enrollment, you must wait until the next Annual Benefits Enrollment period to enroll. See the "Annual Benefits Enrollment" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

Increasing coverage

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). See the "Annual Benefits Enrollment" section in "Chapter 1: Eligibility, Enrollment, and More" for more information. Coverage is generally effective the following January 1 if you are still actively at work on that date; dependents are subject to the nonconfinement clause. See the "Delayed effective date" section on page 14-4 for more information.

However, 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, subject to the nonconfinement clause, through the last day of the plan year that follows the next Annual Benefits 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 the Annual Benefits Enrollment period 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 (access using the instructions in the "Contacts" section on page 14-2).

Decreasing or canceling coverage

You cannot cancel your basic coverage.

You may decrease or cancel your optional coverage at any time by submitting the change in Workday.

You must drop your dependent from coverage in Workday when they are no longer eligible. See the "You must drop ineligible dependents" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

The effective date for decreasing or canceling your optional coverage during the year is the first of the month after your election change is submitted in Workday.

Cost

Wells Fargo pays the full cost of premiums 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 of premiums for Optional Critical Illness Insurance coverage, including premiums for coverage for eligible enrolled dependents. Each pay period, you pay the premiums 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 the coverage option you select (tobacco user or non-tobacco user), your age (as of December 31 of the preceding year), 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 were 39 years of age on December 31 at the end of last year and enroll in Optional Critical Illness coverage, your premium will be based on the age 35-39 age range for this year's payroll deductions. However, for next year's 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 do not use any tobacco products are lower than the premium rates for tobacco users. Tobacco products include but are not limited to cigarettes, electronic cigarettes, cigars, pipes, and chewing tobacco.

If your tobacco user status changes after you enroll, call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2 to request a change to your Optional Critical Illness coverage to reflect your current tobacco use status. The change will be effective the first of the month following your call to Employee Care. Tobacco user status cannot be changed retroactively.

For example, if you enroll as a tobacco nonuser but later begin to use tobacco products, you must change your status to tobacco user. Conversely, if you enroll as a tobacco user and stop using any tobacco products, you may change to tobacco-nonuser status. In either case, the new premium will be effective the first of the month following your call to Employee Care.

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

You may designate a beneficiary. If you are deceased at the time benefits are payable, the benefit will be paid to your designated beneficiary. See the certificate for more information, including what happens if you do not designate a beneficiary. To view the certificate, visit metlife.com/mybenefits (access using the instructions in the "Contacts" section on page 14-2).

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 (access using the instructions in the "Contacts" section on page 14-2), 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 provides Basic Critical Illness Insurance coverage for eligible employees and provides Optional Critical Illness Insurance coverage for eligible employees and eligible dependents who are enrolled in Optional Critical Illness Insurance coverage. The plan will pay a lump-sum benefit if you or your covered family member is enrolled in the Critical Illness Insurance Plan and provide acceptable proof of a diagnosis made (as determined by MetLife) that occurs while coverage is in effect, for one of the covered conditions listed in the certificate. Review the certificate (basic or optional) for the schedule of covered benefits and conditions and the limitations and exclusions as well as how to submit proof. To view the certificate, visit metlife.com/mybenefits using the instructions in the "Contacts" section on page 14-2.

Payment of the critical illness benefits under the plan 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. 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.

Benefit payments are subject to all of the conditions, maximums, limitations, exclusions, proof requirements, definitions, and terminology stated in the Group Policy insurance documents (as described in the "General Information" section on page 14-3), including the certificate applicable to your state of residence.

Critical Illness Insurance Plan claims and appeals

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 (access using the instructions in the "Contacts" section on page 14-2). 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.

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 Section 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 (access using the instructions in the "Contacts" section on page 14-2).

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 (access using the instructions in the "Contacts" section on page 14-2).

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 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. Wells Fargo continues to pay the premiums.
- If your Optional Critical Illness Insurance coverage is already in effect on the date your approved leave of absence starts, coverage may continue as long as you continue to pay the premiums while on your approved leave.

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. See the "Annual Benefits Enrollment" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

Coverage for terminated employees who are receiving Wells Fargo severance pay

For information, refer to the "Coverage for terminated employees who are receiving Wells Fargo severance pay" section in "Chapter 1: Enrollment, Eligibility, and More."

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: Other Notifications and Disclosures."

If you die, coverage ends on your date of death.

Optional Critical Illness Insurance coverage for your covered dependents ends on the last day of the month in which 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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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 • From work: No sign on or registration required. Go to HR Services & Support, select HR Tools, and click MetLife My Benefits. • From home: Go to metlife.com/mybenefits and follow the instructions to set up your online MetLife account (enter Wells Fargo for "Employer").
Questions about claims or appeals or to get a printed copy of the applicable certificate	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: Other 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 coverage effective date, you can view your state-specific certificate as detailed in the below paragraph. 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") constitute the official plan document for the Optional Accident 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 Optional Accident Insurance Plan, you will be able to access the state-specific certificate for your state of residence through the MetLife MyBenefits site (access using the instructions in the "Contacts" section on page 15-2). If you would like a free printed copy of the state-specific certificate for your state of residence, call MetLife (see the "Contacts" section on page 15-2).

Before your effective date, you can also 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.

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.

Optional Accident Insurance Plan highlights

The Optional Accident Insurance Plan is an optional plan that you can elect to help provide financial protection for you or your family if you or your covered family member experiences a covered injury due to an accident.

- Regular and fixed term employees can elect coverage for themselves and their eligible dependents
  - You have to enroll yourself in order to enroll eligible dependents
- The plan provides a predetermined benefit payment that varies based on the type of covered accidental injury or specific covered medical service or treatment. See the certificate for full benefit details on the MetLife site at metlife.com/mybenefits (access using the instructions in the "Contacts" section on page 15-2)
- You pay the premiums

See the "Optional Accident Insurance Plan benefits" section on page 15-5 and the certificate on the MetLife site: metlife.com/mybenefits (access using the instructions in the "Contacts" section on page 15-2) for details about benefits and coverage. You, or your eligible dependent, must be enrolled in the Optional Accident Insurance Plan on the date of diagnosis to receive benefits.

The Optional Accident Insurance Plan is not medical coverage and should not be considered a replacement for enrolling in medical coverage.

Who's eligible

Regular and fixed term Wells Fargo employees are eligible to enroll in the Optional Accident Insurance Plan. If you enroll as an eligible employee, you may also cover your eligible dependents including your spouse or domestic partner.

However, the following individuals are not eligible for the Optional Accident Insurance Plan:

- Interns and their dependents
- Flexible employees and their dependents
- 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

Detailed eligibility requirements are described in the "Who's eligible to enroll" section of "Chapter 1: Eligibility, Enrollment, and More."

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 (access using the instructions in the "Contacts" section on page 15-2).

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.

How to enroll and when coverage begins

See the "How to enroll" section in "Chapter 1: Eligibility, Enrollment, and More" for the time frame and process for enrollment as a new hire, rehire, or if you have an employment classification change and become eligible to enroll in benefits.

Eligible employees may elect one of the following:

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

After you have enrolled, coverage will begin as described in the "When coverage begins" section in "Chapter 1: Eligibility, Enrollment, and More." Also see the "Delayed effective date" section on this page.

If you do not enroll or elect coverage for your eligible dependents when you are first eligible, you must wait until the next Annual Benefits Enrollment period to make an enrollment election. See the "Changing or canceling coverage" section on this page for more information.

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

Late enrollment

If you did not enroll in Optional Accident Insurance during your initial designated enrollment period or at Annual Benefits Enrollment, you must wait until the next Annual Benefits Enrollment period to enroll. See the "Annual Benefits Enrollment" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

Increasing coverage

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). See the "Annual Benefits Enrollment" section in "Chapter 1: Eligibility, Enrollment, and More" for more information. Coverage is generally effective the following January 1.

However, 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, subject to the non-confinement clause, through the last day of the plan year that follows the next Annual Benefits 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 the Annual Benefits Enrollment period 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 (access using the instructions in the "Contacts" section on page 15-2).

Decreasing or canceling coverage

You may decrease or cancel your overage at any time by submitting the change in Workday.

You must drop your dependent from coverage in Workday when they are no longer eligible. See the "You must drop ineligible dependents" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

The effective date for decreasing or canceling your optional coverage during the year is the first of the month after your election change is submitted in Workday.

Cost

You pay the full cost of premiums for Optional Accident Insurance coverage, including coverage for eligible enrolled dependents. Each pay period, you pay the premiums 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

You may designate a beneficiary. If you are deceased at the time benefits are payable, the benefit will be paid to your designated beneficiary. See the certificate for more information, including what happens if you do not designate a beneficiary. To view the certificate, visit metlife.com/mybenefits (access using the instructions in the "Contacts" section on page 15-2).

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 (access using the instructions in the "Contacts" section on page 15-2) 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 provides coverage for eligible employees and eligible dependents who are enrolled in the plan. The plan provides a payment to you if you or your covered family member is enrolled in the Optional Accident Insurance Plan and provides acceptable proof of a covered accidental injury or covered medical services related to a covered accident (as determined by Met Life) that occurs while coverage is in effect for the injuries and services listed in the certificate. Review the certificate for the schedule of covered benefits and conditions and information on what is not covered, as well as how to submit proof. To view the certificate, visit metlife.com/mybenefits using the instructions in the "Contacts" section on page 15-2.

Payment of the accidental injury benefits under the plan 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. 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.

Benefit payments are subject to all of the conditions, maximums, limitations, exclusions, proof requirements, definitions, and terminology stated in the Group Policy insurance documents (as described in the "General Information" section on page 15-3), including the certificate applicable to your state of residence.

Optional Accident Insurance Plan claims and appeals

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" (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.

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 Section 502(a) of ERISA (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 (access using the instructions in the "Contacts" section on page 15-2).

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

Coverage while on a 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 as long as you continue to pay the premiums while on your approved leave. 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. See the "Annual Benefits Enrollment" section in "Chapter 1: Eligibility, Enrollment, and More" for more information.

Coverage for terminated employees who are receiving Wells Fargo severance pay

For information, refer to the "Coverage for terminated employees who are receiving Wells Fargo severance pay" section in "Chapter 1: Enrollment, Eligibility, and More."

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: Other Notifications and Disclosures."

If you die, coverage ends on your date of death.

Coverage for your covered dependents ends on the last day of the month in which 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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Chapter 16: Global Business Travel & Accident Plan

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Contacts

Information about Global Business Travel and Accident Plan benefits	**1-866-870-3475** (reference Group number 911689 when calling) The UnitedHealthcare Global Business Travel line is available 24/7. International calls are accepted at **1-763-274-7364**. Access the Plan's certificate of coverage online at https://worldwatch.uhcglobal.com/. Use the Wells Fargo Global Travel ID 313291 and your work email address.
Obtain your ID card online	Download an ID Card before traveling by going to https://worldwatch.uhcglobal.com/. Use the Wells Fargo Global Travel ID 313291 and your work email address.
Questions about claims or appeals	**1-866-870-3475** (reference Group number 911689 when calling) International calls are accepted at **1-763-274-7364**.

The information in this booklet and the corresponding certificate of coverage ("certificate") available from UnitedHealthcare Insurance Company) constitutes the Summary Plan Description ("SPD") for the Wells Fargo & Company Global Business Travel and Accident Plan (the "Plan"). Refer to the certificate for information about your benefits, and any exclusions or limitations. Refer to this booklet for information on eligibility, enrollment, and when coverage begins and ends. If there is a conflict between this booklet and the certificate, this booklet will control except with respect to the schedule of benefits, coverage, exclusions and limitations, and claims and appeals sections of the certificate.

The basics

General information

The Plan offers the following three types of coverage for eligible employees travelling outside the United States on approved Wells Fargo business trips of less than 6 months:

- Supplemental medical benefits for medically necessary expenses you incur while traveling
- Evacuation benefits
- Repatriation benefits

For coverage details and other important information about Plan benefits, access the certificate online at https://worldwatch.uhcglobal.com/. Use the Wells Fargo Global Travel ID 313291 and your work email address.

As always, it is between you and your provider to determine the services and supplies you will receive. The provisions governing this Plan control what, if any, benefits are available for the services or supplies you receive. The fact that a service is recommended or a physician has performed or prescribed a service, supply, procedure, or treatment, or the fact that it may be the only option for a given condition, sickness, or illness does not mean that it is a covered service under the Plan. The definition of a covered service or eligible expense may differ from what your provider believes should be covered.

Wells Fargo pays the premium for coverage.

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

Insurer and claims administrator

The Plan is fully insured by UnitedHealthcare Insurance Company ("UHC") under group number 911689.

UHC is the named fiduciary for purposes of claims and appeals and has sole and discretionary authority to interpret the Plan and to make benefit determinations. Wells Fargo is the plan administrator and retains all other authority not delegated to UHC, including eligibility determinations.

Global Business Travel and Accident Plan coverage

The Plan provides certain supplemental medical, evacuation, and repatriation benefits for employees eligible for the Global Business Travel and Accident Plan who are traveling outside the United States (U.S.) for approved Wells Fargo business trips of less than 6 months. Supplemental medical coverage means this Plan pays benefits secondary to your comprehensive medical plan for expenses you incur outside the U.S. The Plan should not be considered a replacement for enrolling in major medical coverage.

General information above coverage and claims is stated in this SPD. Detailed information about coverage and claims is stated in the certificate. To view the certificate or obtain a claim form, visit https://worldwatch.uhcglobal.com/ using the Wells Fargo Global Travel ID of 313291 and your work email address.

Global Business Travel and Accident Plan at a glance

Who's eligible	Regular and fixed-term employees on U.S. payroll who are traveling outside the United States on approved Wells Fargo business trips of less than 6 months
Who's not eligible	Interns, flexible employees, and dependents
Supplemental Medical Benefits	The Plan pays for emergency, urgent care, and emergent care (benefits services that if not provided would likely result in hospitalization) while you are traveling on approved business for Wells Fargo on trips of less than 6 months.
Evacuation and Repatriation Benefits	The Plan pays for emergency medical evacuations, medical repatriation, and repatriation of remains.
Annual Maximum Benefit amount	For any combination of covered medical benefits and evacuation and repatriation benefits: $1,000,000 per covered person per year Some services have separate benefit limits.
Coverage effective date	Coverage starts on the first date of approved Wells Fargo business travel outside of the United States on a trip of less than 6 months.
Cost	Wells Fargo pays the premium for coverage.

Who's eligible

You are eligible if you are classified as a regular or fixed term Wells Fargo employee on U.S. payroll and travelling on approved Wells Fargo business outside of the United States. In addition, you must be enrolled in a Wells Fargo medical option or show that you have other major medical coverage such as coverage through your spouse's employer's plan that is considered "minimum essential coverage" under the Affordable Care Act.

Interns, flexible employees, and dependents are not eligible for coverage. Also, employees on an "international assignment" in a country other than the United States, and have an "international assignment agreement" in force are not eligible for coverage.

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. For purposes of this Plan, an employee is a person who is employed by Wells Fargo or a participating subsidiary or affiliate of Wells Fargo, who is on the Wells Fargo U.S. payroll system, and whose income for this employment is 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 this SPD. Eligibility for Plan benefits is based on the terminology and corresponding definitions presented in this SPD.

Employee type	Definition
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.
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.
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)
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. 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.

How to enroll and when coverage begins

You are not required to enroll in the Plan.

If you are eligible for the Global Travel and Accident Plan, coverage automatically starts on the first date of approved Wells Fargo business travel outside of the United States on a trip of less than 6 months.

Changing or canceling coverage

You cannot change coverage.

Coverage is automatically canceled when you return to the United States from approved Wells Fargo business travel.

Cost

Wells Fargo pays the full cost for premiums of the Global Business Travel and Accident coverage.

Plan benefits

Benefits

This is a summary of benefits available to you under the Plan. Payment of the benefits under the Plan are subject to all of the conditions, maximums, limitations, exclusions, proof requirements, definitions, and terminology stated in the certificate. **Review the certificate for details.** To view the certificate, visit https://worldwatch.uhcglobal.com/ using the Wells Fargo Global Travel ID of 313291 and your work email address.

Generally, the Plan pays benefits for eligible expenses of covered medical services while you are traveling outside the United States on approved Wells Fargo business trips of less than 6 months. The Plan also provides coverage for certain evacuation and repatriation services if needed while you are traveling outside the United States on approved Wells Fargo business trips of less than 6 months. Evacuation and repatriation services require pre-service notification to and approval by UHC.

The Plan may pay benefits for eligible expenses of covered services during personal travel in connection with your business trip. The personal travel can take place before, during or after the approved business trip. Benefits for personal travel are limited to seven days. For example, if you are in London on business for a month but decide to go to Paris, France for a weekend and require medical care while in France, you may be able to receive benefits for eligible expenses related to covered services while in France.

For any combination of medical, evacuation, and repatriation benefits, there is a maximum annual benefit of $1,000,000. Some services have separate benefit limits.

Eligible expenses are the amount UHC determines that the Plan will pay for benefits. You are responsible for paying, directly to the provider, any difference between the amount the provider bills you and the amount the Plan pays for eligible expenses. Eligible expenses are determined solely in accordance with UHC's reimbursement policies described in the certificate.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated. There is no annual deductible and no copayments or coinsurance for the eligible expenses for covered services. You pay for all expenses above the eligible expense amount, above any stated benefit limitation, for services not covered and all amounts that exceed the combined annual maximum benefit.

Exclusions

Review the certificate for limitations and exclusions.

Filing claims and appeals

You have certain rights and obligations with respect to claims for benefits. The details about those rights and obligations, including but not limited to the time period for filing claims, where to file claims, the time period during which you can expect to receive a benefit payment or claim determination, and the time period for appealing any adverse benefit determination are generally stated in the certificate. **Review the certificate for details.** To view the certificate or obtain a claim form, visit https://worldwatch.uhcglobal.com/ using the Wells Fargo Global Travel ID of 313291 and your work email address.

However, we have identified the basic rights and obligations of both the Plan and you with respect to claims and appeals, as prescribed by ERISA. Separate provisions may apply based on state law.

For purposes of this SPD, an "adverse benefit determination" means a denial, in whole or part, of any request for pre-service notification approval or post-service benefits from the Plan. Pre-service notification approval is required for certain services before services are received in order to receive benefits under the Plan. Post-service means you have filed a claim for benefits after services have been received.

- You have the right to request pre-service notification as required under the Plan and file a claim for Plan benefits or 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 UHC's reasonable procedures. You may be required to submit a completed authorization form or other written authorization to designate your authorized representative. The fact that a provider or someone else submits a claim on your behalf does not make them an authorized representative.

  - 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 are described in the certificate.
- If you receive an adverse benefit determination, you will receive a notice of the adverse benefit determination that give you 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 UHC 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

UHC (the insurer) is the named claims fiduciary for the Plan and shall have sole and discretionary authority to determine conclusively for all parties and, in accordance with the terms of the documents or instruments governing the Plan, any and all questions arising from the following:

- Administration of Plan claims and interpretation of all provisions of the 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 Insurance policy

Decisions by UHC shall be conclusive and binding on all parties.

Plan benefits are fully insured by UHC. Neither the plan administrator nor Wells Fargo provides any review of claims made or pays any benefits to Plan participants.

Legal action

No legal action can be taken until the Plan's claims and appeals procedures have been exhausted. You cannot bring any legal action against UHC to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in the certificate.

You cannot bring any legal action against UHC, the Plan, Wells Fargo, or the plan administrator for any other reason until you have completed all the steps in the appeal process described in the certificate. After completing the appeal process, if you want to bring a legal action you must do so within three years of the date UHC notified you of its final decision on your appeal or you lose any rights to bring such an action.

Right of recovery

If, at any time, UHC determines that benefits paid under this Plan were more than the benefits due:

- You, or any other person or entity, to whom UHC overpaid benefits have the obligation to reimburse UHC for the amount of the overpayment.
- UHC has the right to recover the amount of any overpayment from you, or any other person or entity to whom UHC overpaid benefits, including offsetting future benefits payable under the 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 UHC.

When coverage ends

Coverage under the Plan ends when you return to the United States. Coverage under the Plan also ends when the Plan is discontinued or terminated.

Conversion

There is no conversion option for this Plan.

Other notifications and disclosures

Important notice for employees with a Health Savings Account (HSA)

The medical coverage offered under the Plan is considered supplemental coverage and pays benefits secondary to your comprehensive medical plan. This means that if you

travel internationally the Plan will impact the maximum HSA contribution you can make if you are enrolled in a high deductible health plan with a Health Savings Account (HSA). If you will be traveling internationally on the first of any month, you should stop your HSA contribution for that month. You may stop your HSA contributions and re-start your contributions via payroll upon your return through Direct Access on Workday.

Your rights under ERISA

The Plan is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA gives you rights as a participant in the Plan.

Receive information about your plan and benefits

As a participant in an ERISA-covered plan, 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.

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 Ave., N.W.
Washington, D.C. 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.

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.

Plan number

The plan number for the Wells Fargo & Company Global Business Travel and Accident Plan is 545.

Plan sponsor

Wells Fargo & Company is the plan sponsor. Please use the address below for any correspondence to the plan sponsor and include the plan name and plan number in your correspondence:

Global Business Travel & Accident
Plan Sponsor
Wells Fargo & Company
MAC N9310-112
550 S. 4th St.
Minneapolis, MN 55415

Plan administrator

The plan administrator for purposes of ERISA §3(16)(A), is Wells Fargo & Company's Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), the Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), and the Head of Benefits (or the functional equivalent title of the most senior position in Human Resources over benefit plans and programs other than the Head of Human Resources and the Head of Total Rewards), each of whom, acting individually or jointly, may take action as the plan administrator, or its or their authorized delegate. The plan administrator has full discretionary authority to administer and interpret the plan. 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 N9310-112
550 S. 4th St.
Minneapolis, MN 55415

To contact the plan administrator, you may also contact Employee Care by accessing chat, submitting an HR Request through HR Services & Support, or by phone at 1-877-HRWELLS (1-877-479-3557), option 2.

Agent for service

Wells Fargo & Company's Corporate Secretary, at the address below, is the designated agent for service of legal process for the Plan. 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 UHC, contact UHC.

No legal action can be taken against any party with regard to a claim for benefits under the Plan until the applicable claims and appeals procedures described in this SPD 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 UHC notified you of the adverse benefit determination.

Plan year

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

Future of the Plan

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

Plan amendments

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

Plan termination

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

Chapter 17: Employee Assistance Program

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Contacts

In an emergency	**Call 911** (local emergency service) **Call 988** National Crisis and Suicide Prevention Lifeline If you are experiencing a crisis, a life-threatening event or critical situation such as thoughts of suicide or other serious risk of imminent harm, and need immediate assistance, call 911 or 988 service or go to the nearest hospital emergency room.
Employee Assistance Program	1-888-327-0027 The Employee Assistance Program is available 24-hours a day, 7 days a week, 365 days a year. There is no limit on the number of times you can call.
Information about enrollment	Enrollment of employees is automatic upon date of hire. Eligible dependents can enroll at any time by calling the Employee Assistance Program at the number above for services.
Information about premiums	There are no premiums for the Employee Assistance Program.

The basics

This Summary Plan Description ("SPD") summarizes the major features of the Employee Assistance Program ("EAP" or "plan"). An SPD explains your benefits and rights under the corresponding benefit plan. Every attempt has been made to make the SPD for this EAP benefit easy to understand, informative, and as accurate as possible. Read the SPD carefully; however, you should not rely on this document other than as a general summary of the features of the EAP benefit.

In case of any conflict between the SPD or any other information provided and the official plan document, the official plan document governs. (In some cases, portions of the SPD 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 plan administrator (see the "General plan information" section on page 17-10 for address information).

The EAP provides confidential consultation, referrals, and counseling sessions for work and personal concerns. The EAP is a "welfare benefit plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA). The EAP is not medical coverage and should not be considered a replacement for enrolling in medical coverage. Participation in the plan does not constitute a contract or a guarantee of employment with Wells Fargo & Company or its subsidiaries or affiliates. Plan benefits depend on continued eligibility. It is the intention of Wells Fargo & Company that the benefits under the EAP are exempt from the Patient Protection and Affordable Care Act as excepted benefits and any medical benefits provided under the EAP are limited in accordance with 29 C.F.R. §2590.732(c)(3)(vi).

Who's eligible

Eligible employees

The Employee Assistance Program is available to all employees (regular, fixed term, flexible, and interns) on U.S. Payroll; you do not have to enroll in a Wells Fargo-sponsored medical plan or any other benefit option to have access to the EAP. **Note:** Eligibility for purposes of the EAP is determined differently than for other benefit plans or programs sponsored by Wells Fargo. The fact that an individual can participate in the EAP does not necessarily entitle the individual to participate in any other benefit plans or programs sponsored by Wells Fargo.

Eligible dependents

When you are enrolled in the Employee Assistance Program as an employee, your eligible dependents also have access to the EAP resources. Eligible dependents include your spouse or domestic partner, and your dependent children. Dependent eligibility requirements are described in the "Dependent Eligibility" table starting on page 17-4. Parents or legal guardians must call on behalf of dependents under age 18.

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 enrolled as a dependent may not also be enrolled as an employee. (In other words, you are not eligible for double the sessions if you are both an employee and a dependent or are a dependent of more than one employee.)

By enrolling your dependents, you are affirming that each dependent that you have enrolled under a plan meets all applicable eligibility requirements for the plan as stated in the applicable row of the "Dependent Eligibility" table starting on page 17-4. 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 EAP.

If at any time your enrolled dependent no longer meets applicable eligibility requirements for the plan, you agree to stop using the EAP for the individual.

If you fraudulently enroll an ineligible individual or intentionally misrepresent a material fact regarding an ineligible individual, coverage will be terminated. You may be required to repay all costs incurred by the program and it may be grounds for corrective action, including termination of your employment.

Dependent Eligibility

For the EAP, eligible dependents include:

	Eligible	Not eligible
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 EAP as an employee • Your spouse who is enrolled in the EAP as a dependent of another employee • Your former spouse from whom you are legally separated or divorced
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 current 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 EAP as an employee • Your domestic partner who is enrolled in the EAP as a dependent of another employee • 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

	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: - 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 • A child who meets the above eligibility criteria, is age 26 or older, and is incapacitated (see the "Incapacitated dependent children" section on this page)	• A child who is a Wells Fargo employee and is enrolled in the EAP as an employee • A child who is enrolled in the EAP as a dependent of another employee • A child who is age 26 or older, unless incapacitated (see the "Incapacitated dependent children" section on this page)

Incapacitated dependent children

You may also enroll 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 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

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, if you're asked, 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)

Eligibility Disputes

Review Process

If you believe you or your dependents were denied access to EAP benefits in error, or to have EAP benefits terminated in error, call Employee Assistance Consulting (EAC) at 1-888-327-0027 or 1-877-HRWELLS, Option 4, between 7 a.m. Central Time and 5 p.m. Central Time to request a review of your circumstances. If you are dissatisfied with the determination made by EAC you may submit a written request for a review of EAC's determination to Corporate Benefits, on behalf of the plan administrator, at the following address:

Corp. Benefits, Attn Employee Assistance Consulting
Wells Fargo & Company
MAC N9310-110
550 S. 4th St.
Minneapolis, MN 55415

Corporate Benefits cannot accept requests sent by fax or email.

Before you send a request to Corporate Benefits for review, EAC must have already reviewed your request. Regardless of the timing of your interaction with EAC, Corporate Benefits must receive your written request for review within 120 days from the date of the event when you were denied access to EAP benefits 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 circumstances you believe should be considered by Corporate Benefits
- Supporting documentation, as applicable, that provides additional clarity and substantiates the circumstances at issue

Corporate Benefits, on behalf of the plan administrator, has sole and complete discretionary authority to make decisions relating to eligibility for benefits 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 or termination of coverage that are within the plan administrator's authority are subject to the process described immediately above, and are generally not subject to the "EAP Claims and Appeals" procedures starting on page 17-7.

Corporate Benefits' determination, on behalf of the plan administrator, is conclusive and binding on all parties and is not subject to further review. Before taking any legal action with respect to an eligibility determination, or termination of coverage determination, you must first complete the internal administrative review 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 legal service" row in the "Plan information" section on page 17-10.

How to enroll and when coverage begins

Employee enrollment is automatic and begins the first day of employment.

Eligible dependents can enroll when services are needed by calling the Employee Assistance Program at 1-888-327-0027 and verifying their dependent status.

To access the 6-session in-person or virtual counseling sessions per issue (maximum of 12 sessions in the plan year), employees and eligible dependents can call 1-888-327-0027.

Cost

There is no cost to you or your eligible dependents for using the EAP. Costs associated with the services you receive because of a referral or recommendation (such as benefit copays or coinsurance for office visits or other care) are your responsibility and are not coordinated with this EAP. If you would like to continue counseling sessions beyond what the EAP covers, these additional sessions are your financial responsibility.

How the Employee Assistance Program works

In an emergency

If you are experiencing a crisis, a life-threatening event, or critical situation such as thoughts of suicide or other serious risk of imminent harm, and need immediate assistance, call your local 911 service, the 988 National Crisis and Suicide Prevention Lifeline, or go to the nearest hospital emergency room.

Costs associated with the emergency services you receive are not covered by the EAP and are your responsibility.

Non-emergency services

The Employee Assistance Program is available 24-hours a day, 7 days a week, 365 days a year at 1-888-327-0027. During business hours (7:00 a.m. to 5:00 p.m. Central Time), Wells Fargo Employee Assistance intake representatives receive initial calls, gather basic demographic information, and then route the caller to Optum for support. After 5:00 p.m. Central Time, calls are routed directly to Optum for support. There is no limit on the number of times you can call.

The Employee Assistance Program counselors are professionals with graduate degrees in behavioral health who have experience and training to help you (or your eligible dependents) deal effectively with personal or work-related concerns. The EAP can provide you and your eligible dependent with an immediate telephone consultation or a referral for up to 6 short-term in-person or virtual counseling sessions per issue, with a local network EAP provider, up to a maximum of 12 sessions per plan year. The EAP can identify and refer you to an appropriate provider or facility for additional treatment as may be necessary.

While you can use the EAP phone number at any time, there may be times when you require ongoing counseling in addition to your EAP benefits. If additional resources are needed, the EAP counselor will consider your medical plan coverage and available community resources when making referrals and recommendations. Medical plan coverage and costs associated with the services you receive outside of the EAP because of a referral or recommendation from the EAP (including services from a medical plan or benefit copays or coinsurance for office visits or other care) are not covered by the EAP and are your responsibility. Additionally, your EAP benefits do not need to be exhausted prior to using any medical plan coverage in which you may be enrolled. Neither the plan, the plan sponsor, nor the plan administrator is responsible for the quality of services you may receive from service providers as a result of a referral or recommendation.

What the Employee Assistance Program covers

Services provided

EAP counselors can help you address:

- Personal, relationship, and family difficulties
- Depression, anxiety, or other emotional concerns
- Work concerns
- Couples or family counseling
- Alcohol and drug use
- Child abuse, domestic violence, and threats
- Health matters
- Grief and loss
- Financial or legal matters
- Crisis support
- Natural disasters
- Workplace robberies, and other critical workplace events (for more details, see the "Robbery response services" section on page 17-7)

Robbery response services

The EAP will assist employees in coping with the impact of robberies or traumatic workplace incidents. The EAP offers up to 6 in-person or virtual sessions of individual recovery counseling to any employee as needed, following a robbery or other critical incident occurring at the employee's workplace at no cost to the employee. These 6 sessions are included in the 12 session maximum limitation per plan year. Contact the EAP at 1-888-327-0027 if you would like more information about these counseling sessions.

Confidentiality

Contact with the EAP for assistance concerning personal or work-related problems is strictly confidential and voluntary. Participation in any of these services is not communicated to your manager or anyone else without your expressed permission. All EAP records are kept separate from official personnel files.

Exceptions to confidentiality are made only when you give the EAP written permission to release your records to an identified person or when required by law such as:

- Situations involving threat to yourself or others
- Abuse or neglect of a child or vulnerable adult
- If the EAP receives a court order for records, those records may have to be turned over to a judge

Read the Notice of HIPAA Privacy Rights on HR Services & Support for more information about privacy rules that apply to the Employee Assistance Program.

Benefits when you're not working

You may call the EAP at any time, including nights, weekends, holidays, and PTO days. Your access to the EAP continues while you are on a leave of absence, during your severance eligibility period, and during the continuation period described below.

When coverage ends

Coverage under the Employee Assistance Program ends the earlier of:

- The end of the continuation period described here
  - After your last day of employment or following the last day of your severance eligibility period under the Wells Fargo & Company Severance Plan, coverage under the EAP will continue for you and your dependents, at no cost to you, for 36 months following such date (the "continuation period"). You will not need to enroll in this coverage during the continuation period; it will automatically be provided to you and any eligible dependents. It is your responsibility to keep your address and contact information current; former employees should call 1-877-479-3557, option 1, option 2 with any updates.
- The Employee Assistance Program is discontinued or terminated*

Coverage for your dependents ends when your coverage ends (including the end of the continuation period), when they no longer meet the eligibility requirements, or when the EAP is discontinued or terminated*, whichever is earlier.

* For information on Wells Fargo's ability to amend, modify, or terminate the Employee Assistance Program, see the "Future of the Plan" section on page 17-12.

EAP Claims and Appeals

Claims

General information

The claims and appeals procedures stated in this SPD are intended to comply with applicable regulations by providing reasonable procedures governing the filing of claims, determinations of benefit decisions, and appeals of adverse benefit determinations (denials). You cannot file suit against the Employee Assistance Program (EAP) until you have exhausted the mandatory claims and appeal procedures as described below. These claims procedures do not apply to any claims under a separate medical plan (including the Wells Fargo & Company Health Plan) for services obtained after a referral from the EAP.

Filing a claim

When you receive services from EAP, you will not have any claims forms to file.

Claims will fall within one of the following categories:

- **Pre-service claims.** A request for benefits before a service or supply is received, where the EAP requires you to obtain approval of the benefit in advance of receiving care as a condition of receiving benefits (such as benefits requiring authorization or precertification)
- **Urgent care claims.** A claim is an urgent care claim when pre-service authorization or precertification is required before receiving services and:
  - The timing for pre-service claims described above could jeopardize your life, health, or ability to regain maximum function, or
  - A physician familiar with you and your medical condition believes that the timing of the pre-service claim review described above would subject you to severe pain that could not be controlled adequately without the care that is being considered or otherwise determines that your claim is "a claim involving urgent care"

- **Concurrent care claims.** A request for coverage for continuation of services previously approved by the EAP as an ongoing course of treatment or to be provided over a certain period
- **Post-Service claims.** A request for payment for services that have already been received

If your urgent care claim has been filed improperly, Optum will provide notice to you within 24 hours. You will have 48 hours from receipt of the notice to submit any additional required information needed for Optum to consider your claim properly filed.

If your pre-service, concurrent, or post-service claim has been filed improperly, Optum will provide notice to you within five days, and you will have 45 days from receipt of the notice to submit any additional required information needed for Optum to consider your claim properly filed.

Claim determinations

Generally, Optum will provide notice of its decision on your claim within the following timeframes:

- Urgent care claims: Within 72 hours after the claim is received
- Pre-service (non-urgent) claims: Within 15 days after the claim is received
- Concurrent care claims: Within 24 hours after the claim is received, provided the claim is received by Optum at least 24 hours before the expiration of the previously approved services
- Post-service claims: Within 30 days after the claim is received

If Optum determines that it needs an extension of time to make a claim determination due to matters beyond its control, they will notify you of the reason for the extension and the date it expects to render a decision, but the extension will not exceed 15 days. **Note:** Extensions are not allowed for urgent care claims.

If your benefit claim is denied, Optum will provide written notification to you that includes the following:

- Specific reason or reasons for the denial
- The specific EAP provisions, rules, protocols, or guidelines, as applicable, on which the claim determination was based
- If the claim is denied because sufficient information was not received, a description and explanation of any additional information needed to process your claim
- A description of your right to appeal and the applicable appeal review procedures and applicable time limits
- A statement about your right to obtain copies of documentation related to the decision, without charge
- Any additional information required under applicable law

If your claim is denied based on a medical necessity, experimental treatment, or other similar exclusion or limitation, an explanation of the scientific or clinical judgment used in the claim determination will be provided without charge on request.

Appeals

General information

If your claim is denied, you may be able to resolve the denied claim without filing a formal appeal by calling 1-888-327-0027 and asking for Optum claims department to discuss the situation. If the claim is not resolved with a telephone call (an informal review process), you may file a formal appeal.

Filing a formal appeal

You (or your authorized representative, see the "Authorized Representative" section on this page for more information) may file an appeal within 180 days after receiving notification of the claim denial. Your appeal to Optum must be in writing except in the case of an urgent appeal, which can be made orally by calling Optum at 1-888-327-0027. Send written EAP appeals to:

Optum National Appeals Team
Attn: Appeals Department
PO Box 30512
Salt Lake City, UT 84130-0512

When you request an appeal review, include the following:

- Employer name: Wells Fargo
- Employee name and date of birth (if services were provided to a dependent, also provide the dependent's name and date of birth)
- Date of service and type of service provided
- Service provider name
- An explanation of why you are appealing the claim determination
- Any other information or comments you feel supports your request for approval

Authorized Representative

An authorized representative is an individual you have authorized in accordance with the EAP requirements to file an appeal on your behalf. To authorize someone to represent you through the appeal process, a written authorization signed by you must be submitted with the appeal. Your written authorization must include the following information:

- Your name and date of birth
- The name and address of the person authorized to represent you
- An explanation of the purpose for which they are representing you (for example: appeal for services received in 2023)
- The time period for which the individual will be your authorized representative
- The type of documents, records, or other items that may be requested of or released to the authorized person
- Your signature and date the authorization is signed

Appeal determination

Optum will review the appeal applying the terms of the EAP and has the discretion to interpret the terms of the EAP. Generally, Optum will decide your appeal and provide notice of its decision within the following timeframes:

- Urgent care claim appeal: Within 72 hours after the appeal is received
- Pre-service claim appeal: Within 15 days after the appeal is received
- Concurrent claim appeal: Within 15 days after the appeal is received
- Post-service claim appeal: Within 30 days after the appeal is received

If your appeal is denied, Optum will provide written notification to you that includes the following:

- The specific reason or reasons for the denial
- The specific EAP provisions, rules, protocols, or guidelines, as applicable, on which the claim determination was based
- If the appeal is denied because sufficient information was not received, a description and explanation of any additional information needed to process your appeal
- Your rights to file legal action
- A statement about your right to obtain copies of documentation related to the decision, without charge
- Any additional information required under applicable law

If your appeal is denied based on medical necessity, experimental treatment, or other similar exclusion or limitation, an explanation of the scientific or clinical judgment used in the claim determination will be provided without charge upon request.

Legal action

Any suit for benefits must be brought within one year from the date the final appeal determination was issued. For more information about filing legal action, see the “Agent for legal service” row on page 17-10 under the “General plan information” section.

General plan information

Plan sponsor	Employee Assistance Program Plan Sponsor Wells Fargo & Company MAC N9310-112 550 S. 4th St. Minneapolis, MN 55415 EIN: 41-0449260
Plan administrator The plan administrator for the EAP, for purposes of ERISA §3(16)(A), is Wells Fargo & Company's Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), the Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), and the Head of Benefits (or the functional equivalent title of the most senior position in Human Resources over benefit plans and programs other than the Head of Human Resources and the Head of Total Rewards), each of whom, acting individually or jointly, may take action as the plan administrator, or its or their authorized delegate. The plan administrator has full discretionary authority to administer and interpret the EAP. The plan administrator may delegate duties and authority to others to accomplish those duties.	Employee Assistance Program Plan Administrator Wells Fargo & Company MAC N9310-112 550 S. 4th St. Minneapolis, MN 55415 To contact the plan administrator, you may also contact 1-877-HRWELLS (1-877-479-3557), option 4.
Employer identification number (EIN)	EIN: 41-0449260
Plan number	546
Plan year	January 1 – December 31 (The EAP is a calendar year plan that went into effect May 1, 2023.)
Claims administrator	Optum P.O. Box 30760 Salt Lake City, UT 84130-0760
Agent for legal service No legal action can be taken against any party with regard to a claim for benefits under the EAP until the applicable claims and appeals procedures described in this SPD 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). No legal action can be taken against any party with regard to a dispute of eligibility until the process described in the "Eligibility Disputes" section on page 17-5, has been completed. 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.	Corporate Secretary Wells Fargo & Company 30 Hudson Yards Floor 61 New York, NY 10001-2170 You can also serve legal process on the plan administrator at the plan administrator's address stated above or upon the claims administrator at the following address: CT Corporation System Inc. 1010 Dale St. N. Saint Paul, MN 55117
Type of ERISA plan	Welfare benefit plan

Plan funding

Benefits offered under the EAP are paid from the general assets of the plan sponsor or any participating Affiliates.

Participating Employers

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

No assignment

To the extent permitted by law, and except as specified under the terms of the EAP, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution, or encumbrance of any kind, and any attempt to do so will be void.

Applicable law

The plan described in this SPD shall be governed and construed in accordance with the laws of the State of Minnesota to the extent not preempted by the laws of the United States.

Representations contrary to the plan

No employee or officer of the plan sponsor has the authority to alter, vary, or modify the terms of the plan except by means of a duly authorized written amendment to the plan.

No verbal or written representations contrary to the terms of the plan are binding upon the plan, the plan sponsor, or the plan administrator.

Severability

If a court of competent jurisdiction finds, holds, or deems any provision of the plan described in this SPD to be void, unlawful, or unenforceable under any applicable statute or other controlling law, the remainder of the plan shall continue in full force and effect.

Interpretive authority

If the plan document does not clearly dictate whether each participant is eligible or a benefit is due under the plan, or if a question arises as to the interpretation of the terms of the plan, the plan administrator has the discretionary authority to interpret, construe, and apply the terms of the plan. The plan administrator also will decide any such question, with respect to an individual's eligibility to participate in the EAP.

Your rights under ERISA

The EAP is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA gives you rights as a participant in this plan.

Receive information about your plan and benefits

As a participant in this ERISA-covered plan, 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 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 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

Continue health care coverage for yourself, spouse, or eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event. Review this summary plan description and the documents governing the plan on the rules governing the continuation coverage available to you.

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.

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 Ave., N.W.
Washington, D.C. 20210

Future of the Plan

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

Plan termination

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

Appendix A: Claims and Appeals

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Introduction

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]
  - HSA Plan[1,3]
  - Local Copay Plan with HRA[2]
  - Flex HDHP
- Anthem Blue Cross and Blue Shield administered:
  - HSA Plan[1,3]
  - Local Copay Plan with HRA[2]
  - Flex HDHP
- Centivo administered:
  - Local Copay Plan with HRA[2]
- Express Scripts administered prescription drug benefit:
  - Copay Plan with HRA[1,2]
  - HSA Plan[1,3]
  - Local Copay Plan with HRA[2]
  - Flex HDHP
- 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 and the tobacco surcharge

- If you are enrolled in the Copay Plan with HRA, HSA Plan, or the Local Copay Plan with HRA 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. Because Optum is the administrator 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; you cannot appeal the availability of health and wellness dollars with the claims administrator for your medical plan option. Your inquiry to Optum will function as your appeal with respect to these health and wellness dollars.
- If you are designated as a tobacco user on Workday and have enrolled in Quit For Life® but have not had the tobacco surcharge credited to your pay voucher or otherwise dispute the application of the surcharge or credits, see the "Review process for tobacco surcharge disputes" section in "Chapter 1: Eligibility, Enrollment and More" for information about filing a formal inquiry.
- While neither the health and wellness activities under the Copay Plan with HRA, HSA Plan, or the Local Copay Plan with HRA nor enrollment in Quit For Life® for the tobacco surcharge credit (applicable to all medical plan options except the Flex HDHP and the UnitedHealthcare Global – Expatriate Insurance Plan) are 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 or are unable to enroll in Quit For Life® to qualify for a tobacco surcharge credit. Please see the "Requests for accommodations" section in "Chapter 2: Medical Plans" for more information on how to request an accommodation for health and wellness activities and the tobacco surcharge; 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://choose.kaiserpermanente.org/wells-fargo) 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 in 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. See the "Enrollment and eligibility disputes" section in "Chapter 1: Eligibility, Enrollment and More" for more information.

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. Whether a representative is authorized to act on your behalf will be determined in accordance with the claims administrator's reasonable procedures. For example, you may be required to use a form approved by the 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 valid designation of the provider as your or your covered dependent's authorized representative. Any such assignment will be null and void and will not be recognized or given effect.

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, except where required by applicable state law and appropriately authorized by you to be paid directly to the provider.

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) for the following services subject to the "Surprise billing protections" section in "Chapter 2: Medical Plans" 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** • **HSA Plan** • **Local Copay Plan with HRA** • **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 and Blue Shield administered: • **HSA Plan** • **Local Copay Plan with HRA** • **Flex HDHP**	Anthem Blue Cross and Blue Shield 1-866-418-7749 For urgent care claims, specifically state that the claim is an urgent care claim. Anthem Blue Cross and 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.
Centivo administered: • **Local Copay Plan with HRA**	Centivo 1-833-666-1506 For urgent care claims, specifically state that the claim is an urgent care claim. Centivo 199 Scott Street, Suite 800 Buffalo, New York 14204
Express Scripts administered prescription drug benefit: • **Copay Plan with HRA** • **HSA Plan** • **Local Copay Plan with HRA** • **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.
HealthEquity administered: • **Health Reimbursement Account (HRA) claims under:** – **Copay Plan with HRA** – **Local 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." 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 or the Local Copay Plan with HRA and pay a claim out of pocket instead of using your HealthEquity Visa® 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® Visa® 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** • **HSA Plan** • **Local Copay Plan with HRA** • **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 and Blue Shield administered: • **HSA Plan** • **Local Copay Plan with HRA** • **Flex HDHP**	Anthem Blue Cross and 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.	
Centivo administered: • **Local Copay Plan with HRA**	Centivo 199 Scott Street, Suite 800 Buffalo, New York 14204	**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** • **HSA Plan** • **Local Copay Plan with HRA** • **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. Out-of-network claim submissions should be mailed to: Vision Service Plan Attn: Claims Services PO Box 495918 Cincinnati, OH 45249-5918
HealthEquity administered: • **Health Reimbursement Account (HRA) claims under the:** – **Copay Plan with HRA** – **Local 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://www.healthequity.com (Login to EZ Receipts) • Use the HealthEquity EZ Receipts mobile app on your personal device (not a Wells-Fargo issued device)	• HRA claims under the Copay Plan with HRA or the Local Copay Plan with HRA must be filed within 12 months from the date of service. Refer to the "Non-HealthEquity® Visa® 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" 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 procedures for filing an appeal of the adverse benefit determination.
- 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 (provided you exhaust the Plan's claims and appeal procedures).
- 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, rescissions, and claims subject to balance billing protections (other than payments to the provider) as described in the "Surprise billing protections" section in "Chapter 2: Medical Plans" of this *Benefits Book*, including whether the claim is subject to the balance billing protections 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 (or claim) on your behalf or represent you in the appeal (or claim) process. An assignment of benefits to a provider or facility is not considered to be a valid designation of the provider as your or your covered dependent's authorized representative. Any such assignment will be null and void and will not be recognized or given effect.

To authorize someone (including your physician) to represent you through the internal appeal (or claim) 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 (or claim). 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.

No right, benefit, cause of action arising after the denial of benefits, or any other interest under the plan shall be subject to alienation, sale, transfer, assignment, pledge, or encumbrance or charge, voluntary or involuntary, by operation of law or otherwise, and any attempt at such transaction(s) shall be void. You and/or your dependent may not assign your rights, benefits, causes of action arising after the denial of benefits, or any other interest under the plan to a third party, including any provider or any other individual or entity. Any attempt to assign any right, payment, benefit, or cause of action arising after the denial of benefits under the plan will be null and void and will not be recognized or given effect. Only eligible participants have benefit rights under the plan. In no event will an assignment of benefits constitute a designation of the purported assignee as the covered person's authorized representative. However, benefits under the plan may be subject to a Qualified Medical Child Support Order (QMCSO). The claims administrator may, however, in its discretion pay a provider directly for services rendered to you or your covered dependent(s). The payment of benefits directly to a provider, if any, will be done at a convenience to you and your covered dependent(s) and will not constitute an assignment of rights, benefits, causes of action, or any other interest under the plan or a waiver of this anti-assignment provision.

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 Anthem Blue Cross and Blue Shield, Centivo, 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-15. 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-16.

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 and Blue Shield	Anthem Blue Cross and Blue Shield PO Box 60009 Los Angeles, CA 90060
Centivo	Centivo 199 Scott Street, Suite 800 Buffalo, New York 14204
Express Scripts	Express Scripts Attn: Commercial Claims PO Box 14711 Lexington, KY 40512-4711
Delta Dental	Delta Dental of Minnesota Claims Appeal Dept. PO Box 30416 Lansing, MI 48909
Vision Service Plan (VSP)	VSP Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670
HealthEquity	Claims Administrator HealthEquity 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 N9310-112
550 S. 4th St.
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. If you need additional assistance in filing your appeal, please contact Included Health, at 1-833-200-7683.

Contacts for urgent care claim and concurrent care claim appeals

Benefit option	Contact
UnitedHealthcare administered: • **Copay Plan with HRA** • **HSA Plan** • **Local Copay Plan with HRA** • **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 and Blue Shield administered: • **HSA Plan** • **Local Copay Plan with HRA** • **Flex HDHP**	Anthem Blue Cross and 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.
Centivo administered: • **Local Copay Plan with HRA**	Centivo By phone: 1-833-666-1506 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** • **HSA Plan** • **Local Copay Plan with HRA** • **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.
HealthEquity administered: • **Health Reimbursement Account (HRA) claims:** – **Copay Plan with HRA** – **Local 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."	Not applicable.

Contacts for pre- and post-service claim appeals

Benefit option	Address
UnitedHealthcare administered: • **Copay Plan with HRA** • **HSA Plan** • **Local Copay Plan with HRA** • **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 and Blue Shield administered: • **HSA Plan** • **Local Copay Plan with HRA** • **Flex HDHP**	Anthem Blue Cross and 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.
Centivo administered: • **Local Copay Plan with HRA**	Centivo 199 Scott Street, Suite 800 Buffalo, New York 14204 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** • **HSA Plan** • **Local Copay Plan with HRA** • **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 Claims Appeal Dept. PO Box 30416 Lansing, MI 48909
Vision Service Plan (VSP)	VSP Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670
HealthEquity administered: • **Health Reimbursement Account (HRA) claims under:** – **Copay Plan with HRA** – **Local 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 Appeals PO Box 14034 Lexington, KY 45012 Fax: 1-877-220-3248

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 facilitated by the claims administrator 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 or claims subject to balance billing protections (other than payments to the provider) as described in the "Surprise billing protections" section in "Chapter 2: Medical Plans" of this *Benefits Book*, including whether the claim is subject to the balance billing protections. All other adverse benefit determinations, including but not limited to 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 claims subject to balance billing protections as referenced above, or if you have otherwise exhausted the internal claims and appeals process for a claim involving medical judgment or claims subject to balance billing protections, you have the right to request an external review under the following:

- UnitedHealthcare administered:
  - Copay Plan with HRA*
  - HSA Plan*
  - Local Copay Plan with HRA
  - Flex HDHP
- Anthem Blue Cross and Blue Shield administered:
  - HSA Plan*
  - Local Copay Plan with HRA
  - Flex HDHP
- Centivo administered:
  - Local Copay Plan with HRA

Express Scripts administered prescription drug benefit:

- Copay Plan with HRA*
- HSA Plan*
- Local Copay Plan with HRA
- 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) and 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.
- After the IRO has reviewed your file, 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 page A-19.

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: Other 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 for purposes of internal review. The external review requirements of the Affordable Care Act apply to rescissions of coverage.

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 claims subject to the "Surprise billing protections" section in "Chapter 2: Medical Plans," 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. An independent dispute resolution ("IDR") process prescribed by federal law is available if the provider disputes the claims administrator's benefit determination. 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 disputes concerning the amounts paid to providers for such services with respect to claims subject to surprise billing protections; however, the claims and appeals procedures described herein will continue to apply to any determinations of cost-sharing (such as co-payments, coinsurance, and deductibles) as well as determining whether the services are subject to surprise billing protections. Notwithstanding the foregoing, the IDR process will be administered in accordance with applicable law, regulations, and guidance.

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Your rights under ERISA

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

Receive information about your plan and benefits

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

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

Continue group health plan coverage

You may be entitled to continue health care coverage for yourself, your spouse, your domestic partner, or your dependents if there is a loss of coverage under a Wells 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 submitting a benefits material request on HR Services & Support.

Women's Health and Cancer Rights Act of 1998

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

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

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

The Newborns' and Mothers' Health Protection Act

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

Notice of special enrollment rights under HIPAA

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

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

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

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

Patient Protection Notice

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

PCP designation and referral requirements

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

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

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

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

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

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

Obstetrical or gynecological care

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

Plan information

Employer identification number

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

Plan sponsor

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

Plan Sponsor
Wells Fargo & Company
MAC N9310-112
550 S. 4th St.
Minneapolis, MN 55415

Plan administrator

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

The plan administrator's address is:

Plan Administrator
Wells Fargo & Company
MAC N9310-112
550 S. 4th St.
Minneapolis, MN 55415

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

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

Agent for service

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

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

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

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

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

Plan trustee

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

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

Plan year

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

Disclosure about health savings accounts

Wells Fargo & Company sponsors and maintains high-deductible health plans for plan participants and their eligible dependents that are compatible with a health savings account ("HSA"). However, the HSA itself is not part of any ERISA-covered employee benefit plan sponsored or maintained by Wells 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-5.

Future of the plans

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

Plan amendments

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

Plan termination

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

ERISA plans sponsored by Wells Fargo

Plan name	Plan coverage option	Plan number	Service provider or insurer
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	Copay Plan with Health Reimbursement Account (HRA)* (Self-insured[2]) * Including Out of Area Coverage	537	**Medical** UnitedHealthcare 1-800-842-9722 **Prescriptions** Express Scripts 1-855-388-0352 **HRA claims** HealthEquity 1-877-924-3967
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	Health Savings Account (HSA) Plan*,[3] (Self-insured[2]) * Including Out of Area Coverage	537	**Medical** Anthem Blue Cross Blue Shield 1-866-418-7749 UnitedHealthcare 1-800-842-9722 **Prescriptions** Express Scripts 1-855-388-0352
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	Local Copay Plan with Health Reimbursement Account (HRA) (Self-insured[2])	537	**Medical** Anthem Blue Cross Blue Shield 1-866-418-7749 Centivo 1-833-666-1506 UnitedHealthcare 1-800-842-9722 **Prescriptions** Express Scripts 1-855-388-0352 **HRA claims** HealthEquity 1-877-924-3967
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	Flexible High-Deductible Health Plan (Self-insured[2])	537	**Medical** Anthem Blue Cross Blue Shield 1-866-418-7749 UnitedHealthcare 1-800-842-9722 **Prescriptions** Express Scripts 1-855-388-0352
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser California (Insured[4]) (Northern and Southern California)	537	Kaiser Permanente 1-800-464-4000
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser Colorado (Insured[4])	537	Kaiser Permanente 1-800-632-9700
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

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]	HMO — Kaiser Mid-Atlantic (Insured[4])	537	Kaiser Permanente 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
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser Washington (Insured[4])	537	Kaiser Permanente 1-888-901-4636 Seattle area 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	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Wells Fargo & Company Short-Term Disability Top-Up Plan	Short-Term Disability Top-Up Plan (Self-insured)	523	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Wells Fargo & Company Long-Term Disability Plan	Long-Term Disability Plan (LTD) (Insured[4])	505	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
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 Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2

1. This plan will be known as the Wells Fargo & Company Health Plan (or the Health Plan) throughout this *Benefits Book*.
2. "Self-insured" means benefits are paid for by the plan through a trust. The identified service provider provides claims administrative services and is the claims and appeals fiduciary.
4. "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	Dependent Term Life Insurance coverage (Insured[4])	506	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Life Insurance Plan	Optional Term Life Insurance coverage (Insured[4])	506	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Life Insurance Plan	Spouse/Partner Optional Term Life coverage (Insured[4])	506	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Business Travel Accident Plan	Business Travel Accident (BTA) (Insured[4])	503	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Accidental Death and Dismemberment Plan	Accidental Death and Dismemberment (AD&D) (Insured[4])	518	Metropolitan Life Insurance Company (MetLife) Employee Care Chat or submit an inquiry through HR Services & Support. Phone support is available by calling 1-877-HRWELLS (1-877-479-3557), option 2
Wells Fargo & Company Optional Accident Insurance Plan	Optional Accident Insurance Plan (Insured[4])	548	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Wells Fargo & Company Critical Illness Insurance Plan	Basic Critical Illness Insurance coverage (Insured[4])	547	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Wells Fargo & Company Critical Illness Insurance Plan	Optional Critical Illness Insurance coverage (Insured[4])	547	Metropolitan Life Insurance Company (MetLife) 1-866-549-2320
Wells Fargo & Company Severance Plan	Severance Plan (Insured[4])	512	Wells Fargo & Company Severance Plan Employee Care Displacement Support: 1-877-584-6097

4. "Insured" means benefits are fully insured and paid for by the insurer, which may be an HMO.

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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 HSA Plan 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 HSA Plan, and except as otherwise indicated, this appendix will address the HSA and not the associated high-deductible HSA Plan, generally referred to in this appendix as "HSA-compatible medical plan."

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 with questions.

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 the Wells Fargo-sponsored high-deductible health plan, the HSA Plan, to contribute to an HSA. Eligibility to participate in the HSA Plan 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 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 the HSA Plan 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 from the date you submit your benefit elections, 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

Annual HSA contribution limits

The contribution limits for self-only and family high-deductible health plan coverage are set by federal law.

- For the 2026 tax year, the maximum HSA contribution is:
  - $4,400 for people with self-only coverage
  - $8,750 for people with coverage other than self-only
- 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 vary by compensation category. They are:

Total eligible compensation less than $48,000 year

- $3,100 You only
- $6,550 You + spouse or domestic partner
- $7,450 You + children
- $6,550 You + spouse or domestic partner + children

Total eligible compensation $48,000 to $100,000

- $3,350 You only
- $7,050 You + spouse or domestic partner
- $7,700 You + children
- $7,050 You + spouse or domestic partner + children

Total eligible compensation greater than $100,000

- $3,600 You only
- $7,550 You + spouse or domestic partner
- $7,950 You + children
- $7,550 You + spouse or domestic partner + children

For more information about eligible compensation, see the description starting on page C-6.

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.

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 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 and for any excise tax that may be due. 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 are able to contribute to an HSA through payroll deduction starting on the first pay cycle of the month following your date of hire (or the date of your employment classification change to a regular or fixed term employee) or as soon as administratively feasible following the opening of your HSA provided you have already elected to enroll in the Wells Fargo-sponsored HSA Plan and you have an active HSA at Optum Bank associated with Wells Fargo.

You can 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.

After you elect (or change) 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).

If a contribution is missed due to a leave of absence, or you haven't enrolled in time to have an account set up before the first pay cycle of the month following your date of hire or the date of your employment classification change to a regular or fixed term employee, or your pay is not sufficient to cover your per pay period contributions, HSA payroll deduction amounts will not recalculate to a higher amount per pay period. If you wish to contribute the maximum annual contribution, you may contribute directly through Optum Bank (see the "Contributing through Optum Bank" section on page C-7 of this appendix).

Former employees in their severance eligibility period can continue to make HSA contributions through pre-tax payroll deduction.

Note: If coverage under the HSA Plan terminates, no further payroll contributions may be made to your HSA.

Full-Purpose Health Care FSA grace period

Important: If you were enrolled in the Full-Purpose Health Care Flexible Spending Account (FSA) and had a balance in that account on December 31 of the preceding calendar year, contributions **cannot** be made to your HSA for the current calendar year until April 1. That means neither you nor Wells Fargo can make contributions toward your HSA (including both earned health and wellness dollars and the employer HSA contribution) until April 1, provided you meet all other eligibility criteria.

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."

The amount deposited to your HSA as a result of health- and wellness-related activities counts towards the annual HSA contribution limit for the year.

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 2026:

- You must be eligible for and elect medical coverage under the Wells Fargo-sponsored HSA Plan during your initial election period for medical coverage effective in 2026 and must still be enrolled in the HSA Plan 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 that year.
- 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 the 2026 HSA Plan:

- For employees who became eligible to participate in Wells Fargo-sponsored medical coverage on or before December 1, 2025, the initial election period was the annual benefits enrollment period that took place in the fourth quarter of 2025.
- For employees who became eligible to participate in Wells Fargo-sponsored medical coverage after December 1, 2025, 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), they are ineligible to receive the employer contribution.
- Mid-year enrollments in the HSA Plan due to a Qualified Event or special enrollment right are not eligible for the employer HSA contribution.

Timing of contribution

The employer HSA contribution will be paid in a lump sum in accordance with the following, based on the HSA 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 the HSA Plan effective January 1 of the current calendar year, your employer HSA contribution will be made to your HSA with Optum Bank within approximately 45 days following your HSA eligibility date provided that you did not have a Full-Purpose Health Care Spending Account as of December 31 of the previous calendar year, or had a zero balance in your Full-Purpose Health Care Spending Account as of December 31 of the previous calendar year. If you had a remaining balance in your Full-Purpose Health Care Spending Account as of December 31 of the previous calendar year, the employer HSA contribution will be made to your HSA with Optum Bank in April of the current calendar year. If you had a remaining balance in your Full-Purpose Health Care Spending Account as of December 31 of the previous calendar year and you are in your severance eligibility period, you must still be in your severance eligibility period through April of the current calendar year in order to receive the employer HSA contribution in April.
- If you are a regular or fixed term employee (or a former employee in your severance eligibility period) who newly enrolls in the HSA Plan after January 1 of the current calendar year, your employer HSA contribution will be made approximately 90 days following your HSA eligibility date.

The HSA eligibility date is the first of the month following the regular or fixed term employee (or former employees in their severance eligibility period) enrollment in HSA compatible medical plan coverage that corresponds to the election made during the employee's initial election period. For example, a regular or fixed term employee who elects the HSA Plan for the 2026 plan year during annual benefits enrollment would have an HSA eligibility date of January 1, 2026, while a regular or fixed term employee who is newly hired on April 15, 2026, and elects the HSA Plan coverage during their initial designated enrollment period would have an HSA eligibility date of May 1, 2026.

Amount of employer HSA contribution

The amount of the employer HSA contribution for eligible employees will be based on their eligible compensation (see the "Eligible compensation for employer HSA contributions" section below), HSA eligibility date, and coverage level, as described in the chart below.

The employer HSA contribution will not be increased or reduced if your HSA Plan coverage level in effect on your HSA eligibility date changes after the date the employer HSA contribution is made. The employer HSA contribution counts toward your annual maximum HSA contribution limit (see the "Annual HSA contribution limits" section on page C-4 for more information).

Eligible compensation	HSA eligibility date (Dates below are in 2026)	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 $48,000.00	January 1 to March 31	$500.00	$1,000.00
	April 1 to June 30	$375.00	$750.00
	July 1 to September 30	$250.00	$500.00
	October 1 to December 31	$125.00	$250.00
$48,000.00 to $100,000.00	January 1 to March 31	$250.00	$500.00
	April 1 to June 30	$187.50	$375.00
	July 1 to September 30	$125.00	$250.00
	October 1 to December 31	$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) in Workday as of October 1 of the immediately preceding calendar year.

Find your eligible compensation on Workday 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, 2025, plus eligible incentive compensation, if any, paid to you in the twelve (12) months prior to October 1, 2025. 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, 2025, 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, 2025. 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, 2025, 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 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.

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 the HSA Plan ends, you will continue to own and control the funds in your HSA, whether or not you elect COBRA coverage for the HSA 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 information 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. **Note:** If you had coverage under the Wells Fargo HSA Plan in one year and do not elect coverage in the HSA Plan for the following year, you will continue to own the funds in your HSA but you will be responsible for the monthly service fee and all other fees for your HSA.

You can obtain additional information

- From the IRS website at https://www.irs.gov/publications/p969/ar02.html#en_US_publink1000204020
- From Optum Bank
  - At https://www.optumbank.com
  - By calling 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. The leave of absence programs do not govern Wells Fargo-sponsored benefit plans.

For the purposes of this appendix, the types of leave of absence options available are defined and described in HR Services & Support articles. You can find the leave of absence articles under the "Time & Absence" section or search for leave of absence types using the search bar. You may also call MetLife, the leaves processing claims administrator, at 1-866-549-2320. To file a claim, you may access the MetLife Portal at metlife.com/mybenefits.

- Your leave of absence may be protected under the Family Medical Leave Act (FMLA). If your leave is protected by FMLA, 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, refer to the "Uniformed Services Employment and Reemployment Rights Act (USERRA)" section on page D-5 for applicable information.

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 HR Services & Support 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 timely 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 when your leave of absence begins:

- 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 when your leave of absence begins:

- 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, 4.

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 additional contributions, up to the extent permitted by applicable law 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, military with pay leave or military with supplemental pay leave or benefits under the Texas Injury Benefits Plan) and your claim is approved, your applicable contributions and premiums for elected benefits (for regular and fixed term employees) will automatically be deducted from your income replacement benefit.

If your income replacement pay is not sufficient to cover your costs for your benefit elections, you are still responsible for your contribution or premiums for coverage, including any retroactive contributions or premium adjustments. If you have an outstanding balance that is past due, additional contributions, up to the extent permitted by applicable law, 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, or at its discretion, the plan administrator (or its delegate) may inform you of additional actions that may be taken by it to address your past due balance.

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 that does not have income replacement benefits like personal leave or job search leave, 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: Spouse/Partner Optional Term Life, Optional Term Life, Dependent Term Life, Legal Services, Accidental Death & Dismemberment, Optional Long-Term Disability, Optional Critical Illness Insurance, and Optional Accident Insurance coverage 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 eligible 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, 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, unless your coverage was terminated for nonpayment. If you have an outstanding balance that is past due, additional contributions, up to the extent permitted by applicable law, 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, or at its discretion, the plan administrator (or its delegate) may inform you of additional actions that may be taken by it to address your past due balance.

If your leave type resulted in termination of coverage for Business Travel Accident, 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, Business Travel Accident, 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). Note the following:

- If you are a regular or fixed term employee, you may reenroll in medical, dental, vision, or legal services coverage if you experience an applicable special enrollment right or Qualified Event. If you are a flexible employee, you 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, additional contributions, up to the extent permitted by applicable law, will be deducted from your pay until your outstanding past due balance is zero 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, additional contributions, up to the extent permitted by applicable law, will be deducted from your pay until your outstanding past due balance is zero 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 and receive approval for a completed Statement of Health form through the late enrollment process. For more information about the late enrollment process and Statement of Health form, see "Chapter 7: Life Insurance Plan."
- 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, use HR Services & Support to find articles related to FMLA or call MetLife, the leaves processing claims administrator at 1-866-549-2320.

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. Your company-paid Basic Term Life and Basic Critical Illness Insurance coverage will also 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). 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 Business Travel Accident Plan, 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, 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. Call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, 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), review the "Who is eligible to contribute to an HSA" section 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, see the "Changing Contributions" section in "Chapter 5: Health Care Flexible Spending Account Plan."
- 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 and your Business Travel Accident coverage will be reinstated.

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, 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 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, use the search bar on HR Services & Support to find articles related to USERRA or call MetLife at 1-866-549-2320.

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 to individuals covered under a fully insured California health plan E-10

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 "Additional COBRA 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 (UnitedHealthcare Global — Expatriate Insurance). 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."

* Although a domestic partner is not a "qualified beneficiary" under federal COBRA rules, the Wells Fargo group health plans extend COBRA continuation coverage to domestic partners and treat them as qualified beneficiaries if they experience a qualifying event as described in this Appendix E.

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 "Additional COBRA 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 (as determined in the sole discretion of the plan administrator)

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 (as determined in the sole discretion of the plan administrator)
- 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 (as determined in the sole discretion of the plan administrator)
- The covered employee and spouse divorce or legally separate (applies to the Wells Fargo retiree's covered 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 as described in "Chapter 1: Eligibility, Enrollment, and More" in this *Benefits Book*.

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 will 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 drop your ineligible dependents from coverage as soon as possible and no later than 60 days from the date of the qualifying event by making your enrollment change using Workday. If you are unable to make the change using Workday, you may call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2 for assistance.

* 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.

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 must call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) to initiate a request for a disability extension. A request for disability extension form will be provided to the participant. The participant must provide the completed request for disability extension form, accompanied by a copy of the Social Security Administration's disability determination award letter to BenefitConnect™ | COBRA before the end of the initial 18-month COBRA continuation period and within 60 days of the latter 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: COBRA
PO Box 981915
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 30 days of the Social Security Administration's determination.

- If the qualified beneficiary is determined to no longer be disabled within the original COBRA continuation 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 qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred.

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 secondary to Medicare, even if you are not enrolled in Medicare.

For more information about Medicare, visit https://www.medicare.gov/medicare-and-you.

* Some exceptions apply, such as during the 30-month coordination period when Medicare entitlement is based on ESRD.

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/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Keep your Plan informed of address changes

To protect your family's rights, update any changes in addresses of family members using Workday. If you are an employee unable to make the change using Workday, you may call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2 for assistance. 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 (UnitedHealthcare Global — Expatriate Insurance):

- 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: COBRA
  PO Box 981915
  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.

Additional COBRA information

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.

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[1, 2, 3, 4, 5]
Change in employment classification from flexible to regular or fixed term.	18 months[1, 2, 3, 4, 5]
A covered dependent child stops being eligible for coverage under the Plan as a "dependent child."	36 months[3, 4]
The covered employee and spouse divorce or legally separate, or the covered employee and domestic partner terminate their domestic partnership or civil union.[6]	36 months[3, 4]
The covered employee dies.	36 months[3, 4]
The covered employee's employment terminates (including retirement).	18 months[1, 2, 3, 4, 5]

1. 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.
2. 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).
3. Coverage may terminate before the end of the maximum extension as described in the "End of COBRA continuation coverage" section on page E-10.
4. Participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA can continue only through the end of the current plan year.
5. 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.)
6. 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, 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.

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-10.

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 COBRA continuation coverage will receive COBRA coupons after enrollment is elected. Once initial premium payment is received, a New Continuant/COBRA Benefits Confirmation Statement is sent to the primary account holder. 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, a packet of COBRA payment coupons, with a coupon for each monthly payment due in the current plan year, will be sent and should be used by the qualified beneficiary 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. In other words, your coverage will not be retroactively reinstated until you make your first premium payment. 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 for each subsequent month of continuation coverage are due by the first day of that month. 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 (see the "Important notes" section on this page for more information).

All COBRA payments are due by the first of the month and apply to coverage for that entire month.

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 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.

Changing COBRA continuation coverage

Whenever your status or that of a dependent changes, you must notify BenefitConnect™ | COBRA of the change as soon as possible and no later than 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; some Qualified Events may impact your eligibility for COBRA continuation coverage. 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 and do not have separate and independent COBRA rights. 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*.

End of COBRA continuation coverage

COBRA continuation coverage will end 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 timely 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 timely 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.** BenefitConnect™ | COBRA must be notified as soon as possible if a qualified beneficiary obtains coverage under another group health plan after you elect COBRA continuation coverage. 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 to the date coverage under the other plan became effective.
- **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

For more information about health insurance options available through a Health Insurance Marketplace, visit healthcare.gov.

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.

Appendix F: Severance Plan Summary Plan Description (SPD)

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Contacts

Information about the Plan and claims	Wells Fargo & Company Severance Plan Attention: Severance Plan Administrator MAC F2301-03A 1 Home Campus 3rd Floor Des Moines, IA 50328-0001 Email: SCPPlan.Admin@wellsfargo.com
Information about the Wells Fargo & Company Severance Plan	Employee Care Displacement Support 1-877-584-6097 Monday through Friday 8:00 a.m. to 6:00 p.m. Eastern Time

The basics

There may be times when displacement or substantial position changes are necessary for business reasons. If this happens, affected participants are given advance written notice whenever possible and are provided assistance in locating other suitable positions; in the case of employees who are returning from Medical Leave with no position and no job reinstatement protection, job reassignment assistance is provided to help find or be placed into a suitable position. The Wells Fargo & Company Severance Plan (the Plan) is designed to provide post termination severance benefits to assist eligible employees in these situations while they are seeking new employment. The Plan complies with the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA) and is a "welfare benefit plan" as that term is described under ERISA. As a participant in the Plan, 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 "Appendix B: Other Notifications and Disclosures", including the "Your rights under ERISA" section on page B-2. No person is authorized to make promises regarding benefits under the Plan except as provided in the Plan. Every effort has been made to accurately describe the Plan in this Summary Plan Description (SPD). However, if there should be a discrepancy between the SPD and the Plan, then the Plan document will control.

Who's eligible

Eligible employees

You are eligible to participate in the Plan if you were/are:

- Classified as a regular or fixed-term employee on a Wells Fargo U.S.-based payroll system and you receive written notice of a qualifying event.

Ineligible individuals

You are not eligible to participate in the Plan if you are:

- Classified as an intern. "Interns" are employees who participate in a formal internship program sponsored by Wells Fargo.
- Classified as a Flexible Employee. "Flexible Employees" are employees who work any of the following:
  - work a regular schedule with standard hours of less than 17.5 hours per week as indicated on the Company's HCM System regardless of the actual hours worked,
  - work any number of hours on specific, short-term projects or assignments with a defined end date,
  - work occasional, irregular hours to fill short-term staffing needs such as PTO, short-term leaves, or periodic work volume increases, or
  - work only certain times of the month or year.
- An employee of an affiliate not participating in the Plan. An "affiliate" is a business entity that is under common control with Wells Fargo & Company or is a member of an "affiliated service group," which includes Wells Fargo & Company (as those terms are defined in Section 414(b), (c), and (m) of the Internal Revenue Code). In addition, Wells Fargo & Company may, at its discretion, by action of the Board Chair, President or Chief Executive Officer of Wells Fargo & Company, designate as an affiliate any business entity that is not under such "common control" or a member of such an affiliated service group.
- A person whom Wells Fargo classified as an independent contractor, or any other status by which the individual is not treated as a common law employee of Wells Fargo for purposes of withholding taxes regardless of the individual's 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.)

Disqualifying events

If you are a participant in the Plan, you become immediately ineligible for severance pay and benefits under the Plan if any of the following occur:

a. You are party to a written employment agreement or a separation agreement with Wells Fargo or an affiliate (or a predecessor of Wells Fargo or an affiliate); or you are eligible for a different severance or pay arrangement as set forth in a contractual agreement between you and Wells Fargo or an affiliate; or you are a participant in another plan or program sponsored by Wells Fargo or an affiliate (or a predecessor of Wells Fargo or an affiliate) that provides for severance, change in control, or other forms of severance pay, and the severance or separation pay under such agreement or arrangement is greater than the lump sum value severance pay that would be due under the Plan, as determined by the plan administrator.

b. You are party to or subject to an agreement or other arrangement that provides severance or separation pay separate from what you would otherwise be eligible for under this Plan.

c. You either continue or accept employment with Wells Fargo, accept a new position at Wells Fargo through a job posting process, accept a position with an affiliate or become registered with an affiliate such as a FiNet organization, or you continue or accept a contingent resource assignment aligned to Wells Fargo during your severance eligibility period.

d. You fail to cooperate with Wells Fargo's efforts to retain you as an employee, including complying with the qualified medical release job reassignment process, by declining a reassignment to a new job or job title; or an offer of a position with Wells Fargo or an affiliate that does not qualify as substantial position change, after you have been advised either verbally or in writing that your position will be eliminated, but before your termination of employment. (See the "Substantial position change" section on page F-4.)

e. Wells Fargo or one of its affiliates enters into a corporate transaction with another company (including a transaction where another company acquires all or any portion of the assets, stock, or operations of Wells Fargo) and pursuant to the terms of this transaction, you are either continuously employed or offered continued employment with the other company with terms that meet the definition of a qualifying employment offer, whether or not you accept or decline the offer. **Note:** For purposes of the Plan, the terms of the qualifying employment offer must include: credit for prior service; total base pay at least equal to your total base pay prior to the transfer; a benefits package similar to the package offered by Wells Fargo prior to the transfer (i.e., the package must provide health insurance, a retirement plan/savings plan, and paid time away); and a new work location that is not beyond a reasonable commute distance. If an Employee receives a Qualifying Employment Offer from a third party in connection with a Corporate Transaction and the Employee declines the offer, the Employee will be deemed to voluntarily terminate their employment with the Participating Employer on the effective date of the transaction unless the Employee obtains another position within the Company prior to the effective date. For more information about commute distance, see the "Substantial position change" section on this page.

f. Your employment terminates during the Displacement Notice Period for a reason other than a qualifying event, including but not limited to, your resignation or retirement, your poor performance, or your violation of Wells Fargo's Code of Conduct or employment policies (e.g., engaging in other employment that constitutes a conflict of interest or removing, downloading, or sending information externally in violation of the Information Security Policy or Code of Conduct), whether or not you had already received notice of a qualifying event.

Note: If a Participant informs the Company or Participating Employer of their intent to resign or retire before receiving notice of a Qualifying Event — even if the resignation or retirement occurs after the Displacement Notice Period — they will forfeit severance benefits. This applies regardless of whether the notice is recorded in the Company's HCM system.

g. On the date you would otherwise be eligible to receive written notice of a qualifying event related to position elimination or for a qualifying employment offer in connection with a corporate transaction, you are on a leave of absence and meet any of the following conditions:

- Your leave has no statutory job reinstatement rights for a specifically defined period of time under state or federal laws, unless your leave is qualified medical leave. For more information, see the "Qualified medical leave displacements" section on page F-5.
- Your leave has no job reinstatement rights for a specifically defined period of time under any of Wells Fargo's leave policies.
- You have exhausted the specifically defined statutory period of time for job reinstatement under state or federal laws applicable to your leave (for example, 12 weeks under the Family Medical Leave Act or a similar state statute; five years under USERRA or a similar state statute; or state-mandated workers' compensation statutes).

h. You voluntarily request or accept a change in your position that would otherwise be a substantial position change, including the acceptance of an offer to relocate that you do not timely complete. Accepting an offer for a substantial position change that includes relocation makes you ineligible for severance under the Plan.

i. You experience a qualifying event but refuse to timely sign, or revoke, or fail to comply with the terms of the Agreement and Release. For more information, see the "Agreement and Release of Claims" section on page F-7.

j. You are not on an approved leave or you are on an approved leave beyond 26 weeks subject to the company's leave of absence requirements applicable to approved leaves.

k. You notify the organization, prior to receiving notice of a qualifying event, your intent to leave the organization before what would be the end of your displacement notice period.

l. Prior to or during the severance eligibility period, the company discovers or determines you engaged in misconduct (prior to your termination) that would have led to your termination.

Wells Fargo reserves the right to suspend severance eligibility if you are subject to an investigation. For more information, see the "Qualifying event" section on this page.

Qualifying event

The following events may qualify you for severance pay under the Plan — a position elimination, a substantial position change, a USERRA-related displacement, an Expatriate/Rotational Assignment Displacement, or a qualified medical leave displacement. If you think you qualify for severance pay because of a substantial position change, you must file a claim within 30 days of the date you are advised of the change to your current job. For more information, see the "Filing a claim" section on page F-9.

Position elimination

A position elimination is an elimination of your position or any other form of reduction in force initiated by Wells Fargo. You may be eligible for severance pay if your position is eliminated.

Substantial position change

Subject to the ineligible changes described in the "Ineligible changes" section on page F-5, you may be eligible for severance pay under the Plan, if management changes your existing position or you experience a position elimination and are offered another position, resulting in one of the following:

- A change in your work location where all of the following occur:
  - The distance between previous work location and the new work location exceeds 20 miles (one way).
  - The resultant mileage from home to the new work location exceeds the mileage to the previous work location (one way).
  - The resultant commute from home to the new work location exceeds 40 miles (one way), using a mapping resource for this information as determined by the company. The shortest mileage identified by the mapping resource will be used in determining whether the resultant commute exceeds 40 miles one way.

    Note: Documented full-time telecommuting arrangements that are terminated by management may qualify as a substantial position change if the resultant commute from the employee's home to the new work location exceeds 40 miles (one way).
- A reduction of more than 15% in either:
  - Your covered pay, if your pay category is job class code 2 (see "Covered pay" section on page F-6) which does not include total variable compensation (TVC).
  - Your total base pay, if your pay category is job class code 5, provided that your pre-change covered pay is not maintained at the pre-change level for a six-month transition period. For more information, see the "Covered pay" section on page F-6.
- A change in pay category from job class code 2 to job class code 5 or job class code 1, and vice versa, if your pre-change covered pay is not maintained at the pre-change level for a six-month transition period. No other changes in covered pay will be deemed to be a substantial position change.

If you are informed or believe you have been affected by changes to your position which represent a substantial position change, you must notify the plan administrator of your desire to receive severance pay within 30 days of notice of the substantial position change and must permit the Participating Employer 30 days to cure the change prior to the action becoming a qualifying event. If you accept the position changes, you will not be eligible for severance pay under the Plan.

Displacements related to USERRA job reinstatement efforts

The Uniformed Services Employment and Reemployment Rights Acts (USERRA) provides employees returning from Military Leave with certain rights and protections. You may be eligible for severance pay under the Plan if upon returning from approved Military Leave, you do not have a position, due to a prior position elimination, and either Wells Fargo: 1) does not reassign you to another position, or 2) reassigns you to another position that has a substantial position change. For more information about substantial position changes, see the "Substantial position change" section on page F-4.

Displacements related to completed international assignments or rotational assignments

Following your repatriation from a Wells Fargo-sponsored international assignment or your completion of a Wells Fargo-sponsored rotational assignment, you may be eligible for severance pay under the Plan if management does not place you in a new position or if management identifies a new position for you that qualifies as a substantial position change. For more information about substantial position changes, see the "Substantial position change" section on page F-4.

Qualified medical leave displacements

A qualified medical leave is a medical leave certified by Wells Fargo or its leave administrator that has no job reinstatement rights or continues beyond 26 weeks and does not exceed 24 months.

If you have been released to return to work following a qualified medical leave and your prior position has been eliminated, replaced, or is no longer available, you are expected to actively engage in good faith with the job reassignment process as defined in Wells Fargo policies. Under such circumstances, if you are not offered or placed in a position with Wells Fargo, or you are offered a position that constitutes a substantial position change, you may be eligible for severance pay under the Plan.

Ineligible changes

You are not eligible for severance pay due to other types of position changes that are not qualifying events, including but not limited to the following:

- An increase in the number of hours you work
- A decrease in the number of hours you work, unless the decrease results in a substantial position change
- A change in the days you work each week
- A change in the time you start or stop your job
- A change in your shift or shift differential
- A change in your job responsibilities, your job title, your reporting structure, or any combination thereof
- A management-directed position demotion or position change (which may include a pay reduction or work location move) that results from declining performance or some other form of corrective action
- A management-directed position transfer or lateral move that does not constitute a substantial position change
- A change in the amount of your draw or fixed allowance, if applicable
- A change in the terms of your bonus or incentive compensation plan
- A change in your covered pay due to conditions and restrictions imposed on Wells Fargo under applicable laws, rules, and regulations as determined by the plan administrator

- Termination or change of an alternative working schedule or arrangement, including the discontinuance of remote work, unless the change is a qualifying event
- Prior to or during your displacement notice period, you are offered a position in your previous business unit, from which you received written notice of displacement, and you decline the offer, if the offer was not a substantial position change
- You receive a qualifying employment offer in connection with a corporate transaction and you decline the offer

How the Plan works

If you are an eligible participant, you have a qualifying event, you timely execute and do not revoke the Agreement and Release of Claims (Agreement) provided to you in your displacement support package, are not otherwise disqualified under the Plan, and you abide by the terms of the Agreement then:

- Your employment with Wells Fargo will be terminated at the completion of your displacement notice period. For more information, see the "Displacement notice period" section on page F-7.
- Following your termination of employment, you will receive biweekly post-termination severance payments on Wells Fargo's regularly scheduled paydays based on your completed years of service when the displacement notice period ends and the "Severance pay schedule" on page F-7 (the "severance eligibility period"), unless you submit the Lump Sum Request Form, in which case your severance eligibility period will end, and you will be paid your remaining severance in a lump sum. For more information, see the "Severance pay" section on this page.
- The amount of your biweekly post-termination payments will be determined by your covered pay (refer to the "Covered pay" section on this page).
- You will be eligible to continue participation in some of Wells Fargo's benefit plans such as medical, dental, and vision and life insurance, as defined by the terms of each plan, during your severance eligibility period.
- Resources will be available to assist you in finding new opportunities.
- Eligible deductions that are authorized by you and/or required by state, federal, or local law will be taken from your post-termination severance payments.
- Wells Fargo may integrate your severance pay and any post-termination state-mandated disability benefits and workers' compensation benefits paid to you during the severance eligibility period so that you do not receive more than 100% of your pre-disability covered pay. Any outstanding financial obligation you may have to the company may be taken into account in determining the amount of severance pay for which you are eligible.

Severance pay

The length of time you will be eligible for severance pay is based on your completed years of service and the "Severance pay schedule" on page F-7 (the "severance eligibility period"). Severance pay is your covered pay for the severance eligibility period, unless you are disqualified or the severance eligibility period ends sooner as described in the Plan.

Covered pay

For most participants, the Plan defines "covered pay" as your base salary rate (referred to in the Plan document as the "total base pay") up to a maximum annual base salary of $350,000. This applies to all participants assigned a job class code 2 pay category on the Wells Fargo Human Capital Management System (HCMS). Base salary is your hourly rate of pay multiplied by the number of standard hours indicated on the Wells Fargo HCMS as of the end of the displacement notice period 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 total base pay.

Total base pay includes amounts designated as before-tax contributions to Wells Fargo's employee benefit plans. Total base pay does not include some forms of compensation such as draw, incentives, bonuses (including but not limited to hiring, incentive, and retention bonuses), commissions, overtime pay, shift differentials, noncash awards, or perquisites (such as commute subsidies). For purposes of the Plan, total base pay is converted into a weekly amount.

If Wells Fargo's Total Rewards team assigns your position as a job class code 1 or job class code 5 pay category, the Plan defines "covered pay" as the benefits annual rate indicated on the Wells Fargo HCMS as of the end of the displacement notice period.

Your benefits annual rate is calculated quarterly, and earnings are annualized based on base salary, draw, incentives, bonuses, or commissions paid to you in the last 12 months divided by the number of months with compensation greater than $0. 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. The benefits annual rate calculation does not include some forms of compensation such as overtime pay, shift differentials, hiring and retention bonuses, noncash awards, and perquisites (such as auto allowance or commute subsidies, if applicable). For purposes of the Plan, the benefits annual rate is converted to a weekly amount.

If your job is assigned to the job class code 5 pay category, your covered pay (i.e., the benefits annual rate) for purposes of severance benefits is limited to a maximum of $100,000 per year (or $1,923.07 per week), unless your annual base salary (i.e., total base pay) as shown on the Wells Fargo HCMS is greater than $100,000, then your covered pay for purposes of the Plan is your annual base salary up to a maximum annual base salary of $350,000.

If Wells Fargo's Total Rewards team assigns your position at the job class code 1 pay category, your covered pay is your benefits annual rate up to $265,000 per year.

Completed years of service

Your completed years of service are the number of complete years of employment you have with Wells Fargo and all affiliates as measured from your Continuous Service Date on the Wells Fargo HCMS as of the end of your displacement notice period. Completed years of service for participants who become employees of Wells Fargo or an affiliate in connection with an acquisition may include prior service credit recognized by a predecessor employer provided such service credit is documented in the terms of the corporate transaction. If a Participant incurs a break in service that exceeds six months, service incurred prior to the break in service is not counted for the purposes of this Plan and, in such circumstances, the Continuous Service Date will reflect the new rehire date.

The "Severance pay schedule" section on this page is used to determine the duration of your severance pay. During your severance eligibility period, you will receive post termination severance pay for the number of weeks indicated in the "Severance pay schedule" on this page, unless you become disqualified or the severance eligibility period ends sooner as described in the Plan.

The duration is based on your completed years of service as of the end of the displacement notice period. The weeks are measured from the last day of the displacement notice period. The amount of your biweekly payment will be based on your covered pay at the end of the displacement notice period.

Severance pay schedule

Completed years of service	Severance eligibility period
< 1, 1	8 weeks
2	8 weeks
3	8 weeks
4	8 weeks
5	10 weeks
6	12 weeks
7	14 weeks
8	16 weeks
9	18 weeks
10	20 weeks
11	22 weeks
12	24 weeks
13	26 weeks
14	28 weeks
15	30 weeks
16	32 weeks
17	34 weeks
18	36 weeks
19	38 weeks
20	40 weeks
21	42 weeks
22	44 weeks
23	46 weeks
24	48 weeks
25	50 weeks
26+	52 weeks

Note: You are required to report immediately to Employee Care Displacement Support at 1-877-584-6097 any overpayment paid to you during the displacement notice period or the severance eligibility period. Pursuant to Wells Fargo's Code of Conduct, it is your responsibility to reimburse Wells Fargo for any overpayments. A Wells Fargo representative may notify you when Wells Fargo becomes aware of any overpayment.

Agreement and Release of Claims

To receive severance pay under the Plan, you must timely sign, return, and not effectively revoke the Agreement and Release of Claims (the "Agreement") contained in your displacement packet. In signing the Agreement, you agree to give up any and all claims, actions, or lawsuits against Wells Fargo that relate to your employment with Wells Fargo. In most cases, you will be provided 45 days, beginning with the first day of the displacement notice period to consider the terms of the Agreement, unless the qualifying event stems from a qualifying medical leave.

However, if you are eligible for severance pay, as a result of a qualified medical leave displacement, you will have a minimum of 21 days, as set forth in your displacement packet, beginning on the first day of the displacement notice period to consider the terms of the Agreement.

If you choose not to sign the Agreement in a timely manner or if you revoke the Agreement, you will not receive severance pay.

In all cases, after you sign the Agreement, you will have a seven-day rescission period (15 days in Minnesota) during which you may take action to revoke the Agreement. If you timely sign the Agreement and do not revoke it, severance pay will begin on the next payday following the end of the displacement notice period.

Displacement notice period

The displacement notice period is the period of time designated by the company and communicated to the participant by written notice of a qualifying event during which the participant may consider signing and not revoking the Agreement. The displacement notice period begins on the day identified in the written notice of a qualifying event and at the sole discretion of the company, may be completely nonworking, unless your business unit designates in writing that a portion of the displacement notice period will be working. Once placed on

nonworking notice, you will no longer have authorized access to Wells Fargo systems and secured premises. Changing business needs may affect your nonworking or working status during the displacement notice period. If there is a change, you will be notified.

There may be business circumstances in which participants in a business unit may be provided a shorter or longer displacement notice period, subject to the written approval of the Sr. Human Resource Leader of the business and applicable state law. If your displacement notice period ends before you have completed the 45-day Agreement review period, you will be placed on an unpaid leave of absence the day following the end of your displacement notice period.

This unpaid leave of absence will be terminated immediately:

- Upon Displacement Operations' timely receipt of your executed Agreement and the passing of the revocation period;
- If you become ineligible to participate in the Plan; or
- If you exceed the Agreement review period without executing the Agreement.

If your qualifying event is related to a qualified medical leave, you will receive a minimum of 21 days' displacement notice period, as may be applicable, after the conclusion of a job reassignment effort. You are not expected to be working, unless you accept a position with Wells Fargo.

If you are on an approved leave as of the Notice Date due to a qualifying event and are released to return on or before the expiration of 26 weeks of approved leave, you will have forty-five (45) days from the date you receive the Agreement to consider the terms of the Agreement. An approved leave is time away on company-approved leave of absence with job reinstatement rights for a specifically defined period of time under state or federal laws or under Wells Fargo's policies, as applicable, except for Personal Leave, Job Search Leave, and any involuntary leave based upon one's inability to work in the United States. Participants must comply with the company's requirements to maintain an approved leave status.

Nature of severance pay benefits

Plan benefits are paid from the general assets of your Wells Fargo employer, or a designated fund or trust of Wells Fargo & Company. These assets are subject to the general creditors of Wells Fargo. Wells Fargo is not required to establish a trust to fund the Plan, but may choose to do so at its discretion. Plan benefits may not be assigned. Participants do not make any contributions to the Plan.

Rights to coordinate other pay and benefits

Severance pay under the Plan is not intended to be paid in addition to other types of severance pay such as "Pay-in-lieu of notice", severance paid under other severance plan or programs, written agreements or other applicable laws, such as Worker Adjustment and Retraining Notification (WARN Act) under federal or state law, and will be integrated with any such benefits. In addition, your severance pay may be integrated with the amount of any state-mandated disability benefits and any workers' compensation benefits. Should these other benefits be payable, benefits under the Plan will be reduced accordingly, or alternatively, benefits previously paid under the Plan will be treated as having been paid to satisfy these other benefit obligations. In either case, the plan administrator will determine how to apply this provision and may override other provisions of the Plan in doing so. For more information, see the "Plan administrator" section on page F-10.

Early termination of severance pay

Your severance pay and severance eligibility period may end sooner than described in the "Severance pay schedule" on page F-7, if any of the following applies to you:

- If you accept another position with Wells Fargo or an affiliate, then your severance eligibility period will end and you will not be paid any remaining severance pay.
- If during your severance eligibility period, you submit the Lump Sum Request Form your severance eligibility period will end, and you will be paid your remaining severance in a lump sum severance payment. In the event you accept and begin a new position with Wells Fargo or an affiliate, during the period that would have been part of your severance eligibility period, you will owe Wells Fargo the portion of the lump sum amount paid to you for the period beginning on the rehire date through the date that the severance eligibility period would have ended if you had not requested the lump sum.
- If Wells Fargo determines that you have engaged in conduct that violates Wells Fargo's written policies or otherwise prohibits you from being employed by Wells Fargo, including but not limited to violations of Wells Fargo's Code of Conduct, whether or not such conduct had been discovered while you were actively working for Wells Fargo, then your remaining displacement notice period, the severance eligibility period, or both will end and you will not be eligible for severance pay. Additionally, if you fail to abide by the terms and conditions of the Agreement, your severance pay and severance eligibility period will end, and you will not be eligible to receive any remaining portion of the severance pay. In either of these scenarios, if you were previously paid severance pay you may be required to repay a portion of your severance pay.
- If you receive written notice of a qualifying event during an approved Military Leave or if you are placed on an approved Military Leave during the displacement notice period, your displacement notice period will run concurrently with your approved Military Leave.
- If you die, any remaining portion of your displacement notice period or severance eligibility period will end and your remaining displacement notice period pay (if applicable) and severance pay will be paid to your estate or authorized personal representative as permitted by state law. This payment shall be made as a lump sum severance payment, as soon as administratively practicable, and in accordance with applicable state law following the plan administrator's notification of the participant's death.

Compliance with laws and governance

The determination and payment of benefits under the Plan are subject to the conditions and restrictions imposed under applicable laws, rules, and regulations. Your right to or receipt of benefits under the Plan may be limited, modified, delayed, cancelled, or recovered to ensure compliance with all such applicable laws, rules, and any guidance that may be issued thereunder.

Claims and Appeals

Filing a claim

Typically, Wells Fargo will automatically provide notice to all eligible participants who qualify under the Plan. However, if you have not received notice of your eligibility for benefits under the Plan and you believe that you are entitled to severance pay, or if you believe you are entitled to a larger benefit than outlined in your displacement packet, you may file a written claim with the plan administrator within 90 days of the following:

- The date you receive written notice of a qualifying event and the severance pay available to you under the Plan.
- The first date you learn that you are not eligible for severance pay benefits under the Plan.

Your claim must be in writing and must explain the basis for the claim (including any documentation in support of your claim). The claim should be delivered to the plan administrator by U.S. mail or email (preferred):

Wells Fargo & Company Severance Plan
Attention: Severance Plan Administrator
MAC F2301-03A
1 Home Campus
3rd Floor
Des Moines, IA 50328-0001
Email: SCPPlan.Admin@wellsfargo.com

The plan administrator has delegated the claims review responsibility and administration to Wells Fargo's Severance Plan Administration group. Following the plan administrator's receipt of your claim, you will receive an acknowledgment indicating who will be reviewing your claim (the "claim reviewer"). The claim reviewer will research your claim and will notify you of the decision to approve or deny your claim.

Such notification will be provided to you, within a reasonable period of time, but no later than 90 days from the date your claim is received by the plan administrator. If the claim reviewer determines that an extension of time for processing the claim is needed, the claim reviewer may have up to an additional 90 days. If the claim reviewer reviewing your claim needs an extension, you will be notified before the expiration of the initial 90-day period stating the reason(s) why the extension is needed.

If your claim is denied in whole or in part, the written notification of the decision will state the reason or reasons why your claim was denied and reference specific Plan provisions, SPD provisions, or both, on which the denial is based. If the claim is denied because the Plan did not receive sufficient information, the claims decision will describe the additional information needed and why such information is needed. The notification of the denial decision will also include a statement of your right to bring civil action under Section 502(a) of ERISA if the claim is denied on appeal. Upon your written request, the plan administrator will provide you free of charge with copies of documents, records, or other information relied upon in the determination of your claim (but not confidential information relating to other employees or any restricted information).

Claim denial and appeals

The plan administrator has delegated the responsibility to review appeals to the Severance Plan Appeals Decisioning Group (the "Appeals Decisioning Group"). If all or part of your claim is denied, you or your duly authorized representative may appeal the decision. Within 60 days of receiving the claim reviewer's written notice of denial, your appeal must be filed with the plan administrator (in care of the Appeals Decisioning Group at the address referenced above). For more information, see the "Plan administration" section on page F-10.

An appeal must be in writing and must include the following information:

- Your name
- Reference to the initial decision
- All of the grounds upon which your request for review is based
- Any facts, written comments, documents, records, and other information supporting the request

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim. The review of your appeal will take into account information submitted by you relating to your appeal, even though you may not have submitted such information with your original claim.

The Appeals Decisioning Group will notify you in writing of its final decision within a reasonable period of time, but no later than 60 days after the plan administrator receives your written request for review. In special circumstances, the Appeals Decisioning Group may have up to an additional 60 days to provide written notification of the final decision. If such an extension is required, you will be notified before the initial 60-day period expires, and such notification will state the reasons why the extension is needed and when a decision will be made. If an extension is needed because you did not provide sufficient information, the time period from the notice to you of the need for an extension to when the plan administrator receives the requested information does not count toward the time that the Appeals Decisioning Group is allowed to notify you of the final decision.

If your appeal is denied, the written notification will state the reason or reasons why the claim is denied, will reference specific applicable Plan and SPD provisions on which the denial is based, and will include a statement of your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on appeal.

Upon written request, the plan administrator will provide you free of charge with copies of documents, records, and other information relied upon in the determination of your claim. The plan administrator must receive your written request for information relevant to your claim no later than 120 days after the Appeals Decisioning Group sends you the final written decision. No legal action can be taken against any party with regard to a claim for eligibility or benefits under the Plan until the applicable claims and appeals procedures described in this SPD have been exhausted. Any suit for eligibility or benefits under the Plan must be brought in a court of appropriate jurisdiction within one year of the date of the final appeal determination (or deemed final determination) by the Appeals Decisioning Group under the Plan.

When coverage ends

Your participation in the Plan ends when one of the following occurs:

- You submit a request to end post termination severance pay and benefits
- You no longer meet eligibility requirements
- You have received all the benefits to which you are entitled under the Plan

Plan administration

The Plan name is "The Wells Fargo & Company Severance Plan." The Internal Revenue Service and the Department of Labor identify the plan by its name and by the Plan identification number (PIN): 512. In addition, the Internal Revenue Service has assigned employer identification number (EIN) 410449260 to Wells Fargo & Company. You should use the EIN and the PIN if you correspond with the government about the Plan.

Plan administrator

The plan administrator is Wells Fargo's Head of Human Resources. The plan administrator has full discretionary authority to administer, construe, and interpret the Plan, including its eligibility provisions. The plan administrator may, at any time, delegate to personnel of Wells Fargo, including the Severance Plan Administration group, Employee Relations, and the Appeals Decisioning Group, such responsibilities as it considers appropriate to facilitate the day-to-day administration of the Plan. Communications related to appeals are to be addressed to the plan administrator and should be delivered by U.S. Mail or email:

Wells Fargo & Company Severance Plan
Attention: Severance Plan Administrator
MAC F2301-03A
1 Home Campus
3rd Floor
Des Moines, IA 50328-0001
Email: SCPPlan.Admin@wellsfargo.com

No employee has a vested right to severance pay.

Plan Year

Financial records for the Plan are kept on a calendar year basis, also known as the Plan Year, beginning on January 1 and ending on the following December 31. Provided, however, for any Amendments to the Plan that are effective on a date other than January 1, the first Plan Year under such amendment will begin on the stated effective date and will continue to the end of the calendar year. Thereafter, the Plan Year shall be the calendar year.

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