Summary of Material Modifications
For the Wells Fargo & Company Health Plan

This document is a Summary of Material Modifications (SMM). It is intended to notify you of important clarifications and changes made effective January 1, 2018, to the following medical plan benefit options under the Wells Fargo & Company Health Plan (Wells Fargo Health Plan):

• Health Reimbursement Account (HRA)-Based Medical Plan
• Health Savings Account (HSA)-Based Medical Plan — Gold
• Health Savings Account (HSA)-Based Medical Plan — Silver
• Indemnity Medical Plan — Anthem

This SMM adds to and modifies the Summary Plan Description (SPD) for the medical plans noted above. Specifically, the "Gender reassignment" (Voice modification surgery) and the "Infertility and fertility services and treatment" (Donor coverage) provisions have been modified in Chapter 2: Medical Plans in the Benefits Book, Effective January 1, 2018. This updated information as it relates to "Donor coverage" for 2018 aligns with the 2017 plan provisions and is not a change from 2017.

Please take the time to read this SMM carefully and keep a copy of it with the Benefits Book, Effective January 1, 2018.

If you have questions about the gender reassignment benefit or the infertility and fertility services and treatment benefit, please call your claims administrator.

If you have general questions about the Wells Fargo benefit plans:
• Team members, call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, 2, 1. Representatives are available Monday through Friday, 8:00 a.m. – 5:00 p.m. in your time zone. Team Member Care accepts relay service calls. TDD/TTY users may call 1-800-988-0161.
• COBRA participants, call BenefitConnect™ |COBRA at 1-877-29-COBRA (1-877-292-6272) or 858-314-5108 for International callers only.

Wells Fargo Health Plan
Benefits Book, Chapter 2: Medical Plans
updates effective January 1, 2018

1. In the “Gender reassignment” section beginning on page 2-69 in the Benefits Book, Effective January 1, 2018, “Voice modification surgery” is added to the listing of generally covered expenses. In addition, the last bullet in the “Not Covered” section on page 2-70 is deleted in its entirety to reflect that voice modification surgery is a covered benefit.

2. In the “Infertility and fertility services and treatment” section beginning on page 2-79 in the Benefits Book, Effective January 1, 2018, the “Donor coverage” bullet in “The medical plans cover” section on page 2-80 is deleted and replaced in its entirety with the following:

• Donor coverage. The plan will cover associated donor medical expenses, including collection and preparation of oocyte or sperm. However, any medications for the donor associated with the collection and preparation of oocyte or sperm are not covered. In addition, the plan will not pay for donor charges associated with compensation or administrative services.
A guide to your Wells Fargo benefits

Benefits Book*

Effective January 1, 2018

* For benefits-eligible team members on U.S. payroll
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<td><strong>Delta Dental of MN</strong></td>
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<td>651-994-5342 — Minneapolis/</td>
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<td>• Health and wellness activities for HRA-Based Medical Plan (including Out of Area)</td>
<td>1-877-543-4294</td>
<td>wellness.myoptumhealth.com Or sign on from Teamworks.</td>
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<td>• HRA-Based Medical Plan (including Out of Area)</td>
<td>1-800-842-9722</td>
<td><a href="https://www.myuhc.com">https://www.myuhc.com</a></td>
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<td><strong>Vision Service Plan (VSP)</strong></td>
<td>1-877-861-8352</td>
<td>wf.vspforme.com</td>
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<td><strong>WageWorks</strong> (flexible spending accounts)</td>
<td>1-877-924-3967</td>
<td><a href="https://www.wageworks.com">https://www.wageworks.com</a> Or sign on from Teamworks.</td>
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<td>Short-Term Disability Plan</td>
<td>Liberty Life Assurance</td>
<td>1-866-213-2937</td>
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<td><a href="https://www.mylibertyconnection.com">https://www.mylibertyconnection.com</a></td>
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<td>Long-Term Disability Plan</td>
<td>Liberty Life Assurance</td>
<td>1-866-213-2937</td>
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<td>Company of Boston</td>
<td><a href="https://www.mylibertyconnection.com">https://www.mylibertyconnection.com</a></td>
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<td><a href="https://www.ARAGLegalCenter.com">https://www.ARAGLegalCenter.com</a></td>
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<td>Contact Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2</td>
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## An Introduction to Your Benefits

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### Contacts

| Information about in-network providers | Access the claims administrator’s website (see the applicable chapter in this Benefits Book for specific website information).  
https://mycastlight.com/wf (for medical and dental providers only) |
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<td>Information about your plan</td>
<td>Your plan’s member services phone number or website (see the “Plan Contacts” section at the beginning of this Benefits Book)</td>
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| Information about active team member enrollment, eligibility, making coverage changes, or plan rates and comparisons | Team Member Care (formerly known as the HR Service Center)  
**1-877-HRWELLS** (1-877-479-3557), option 2  
Team Member Care accepts relay service calls.  
TDD/TTY users may call 1-800-988-0161. |
| Information about COBRA enrollment     | BenefitConnect™ | COBRA  
1-877-29-COBRA (16272)  
[(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 team members. SPDs are provided to you at no cost. The Benefits Book is also accessible electronically at teamworks.wellsfargo.com.

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. Refer to the “Summary Plan Descriptions for each benefit plan” table starting on page 1-43 to learn what comprises the applicable SPD for each benefit plan option described in this Benefits Book.

Your responsibility

Each covered team member, COBRA participant, and covered dependent is responsible for reading the 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 team members, eligible former team members who have elected continuation coverage under COBRA (if applicable), and the respective eligible dependents of either of the above. Participation in these plans does not constitute a contract or guarantee of employment with Wells Fargo & Company or its subsidiaries or affiliates. Plan benefits depend on continued eligibility.

• The name “Wells Fargo” as used throughout this document refers to “Wells Fargo & Company.”

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

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

For the Wells Fargo & Company Salary Continuation Pay Plan, the address is:

Plan Administrator
Wells Fargo & Company Salary Continuation Pay Plan
Attention: Enterprise Employee Relations
MAC D1130-110
301 South Tryon Street, 11th Floor
Charlotte, NC 2822-1915

Funding arrangements for the plans

Most benefit plans and benefit options may be either self-insured or fully insured (refer to the “Summary Plan Descriptions for each benefit plan” table starting on page 1-43 to determine if the benefit option is insured or self-insured).

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.

In contrast, when benefits are fully insured by an HMO or other insurer, those insurers are fully responsible for administering and paying benefits.

For information on the Salary Continuation Pay Plan claims administration, refer to “Chapter 12: Salary Continuation Pay Plan.”

Benefit plan options

Wells Fargo sponsors a number of benefit plans providing certain benefits to eligible team members. Some plans may offer more than one type of benefit option. The benefit plans and corresponding benefit options are listed below.

• Wells Fargo & Company Health Plan
  – Health Reimbursement Account (HRA)-Based Medical Plan\(^1\)
  – Health Savings Account (HSA)-Based Medical Plan – Gold\(^2\)
  – Health Savings Account (HSA)-Based Medical Plan – Silver\(^2\)
  – Indemnity Medical Plan — Anthem BCBS, available only to team members living in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan)
  – HMO — Kaiser (in certain locations)
  – High-Deductible Health Plan (HDHP) — Kaiser (in certain locations)\(^2\)
  – POS Kaiser Added Choice — Hawaii (in Hawaii only)

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.”
- Delta Dental Standard
- Delta Dental Enhanced
- Vision Service Plan (VSP)
- Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance, for expatriates only)
- Wells Fargo & Company Health Care Flexible Spending Account Plan
  - Full-Purpose Health Care Flexible Spending Account
  - Limited Dental/Vision Flexible Spending Account
- Wells Fargo & Company Day Care Flexible Spending Account Plan
- Wells Fargo & Company Life Insurance Plan
  - Basic Term Life coverage
  - Optional Term Life coverage
  - Spouse/Partner Optional Term Life coverage
  - Dependent Term Life coverage
- Wells Fargo & Company Business Travel Accident (BTA) Plan
- Wells Fargo & Company Accidental Death and Dismemberment (AD&D) Plan
- Wells Fargo & Company Short-Term Disability (STD) Plan
- Wells Fargo & Company Long-Term Disability (LTD) Plan
  - Basic LTD
  - Optional LTD
- Wells Fargo & Company Salary Continuation Pay Plan
- Wells Fargo & Company Legal Services Plan

In addition, 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 1-43.

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

Who’s eligible to enroll

Eligible team members
Each team member who satisfies the eligibility requirements of a specific benefit plan may enroll in that plan. Your employment classification determines your eligibility to participate in the benefit plans. Regular and part-time team members are considered benefits-eligible team members and are generally eligible for all of the benefit plans, unless indicated otherwise in this Benefits Book or in the official plan documents.

- Regular team members are regularly scheduled to work 30 hours or more per week.
- Part-time team members are regularly scheduled to work 17.5 to 29 hours per week.

For purposes of the employee benefit plans described in this Benefits Book, a team member 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 “team member” does not include (and has not at any time included) a person during any period when he or she is not classified as a Wells Fargo team member (even if that person is later determined to have been a Wells Fargo team member during that period).

Flexible team members are not eligible to enroll or participate in the Wells Fargo-sponsored benefit plans. Flexible team members work on a flexible schedule. For example, flexible team members may work any number of hours on given projects, fill in when needed regardless of hours, remain on call, or work only certain times of the month or year.

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 part-time benefits-eligible team member.
- Be on an “international assignment” in a country other than the United States, and have an “international assignment agreement” in force (this agreement is not part of this Benefits Book or any applicable SPD).
Eligible dependents
Some benefit plans allow you to enroll or cover eligible dependents. When you enroll in one of these benefit plans or corresponding benefit options, you can also enroll or cover your eligible dependents. It is your responsibility to make sure that your dependent meets the eligibility requirements, and by enrolling a dependent you are certifying that your dependent meets the stated eligibility requirements. For the medical, dental, and vision benefit options, and the Life Insurance, AD&D, and Legal Services 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 of this Benefits Book for dependent eligibility information regarding those benefit plans and benefit options. Note that some benefit plans do not provide coverage for dependents.

Note: If, at any time after you enroll, your covered dependent no longer meets the eligibility requirements (for example, loss of foster parent or legal guardianship appointment, divorce of a spouse, or any other event that results in a loss of eligibility), you must notify Team Member Care (formerly known as the HR Service Center) within 60 days of the date your dependent no longer meets the dependent eligibility requirements to drop his or her coverage. If you wait longer than 60 days after the date your dependent no longer meets the dependent eligibility requirements to notify Team Member Care, your dependent may lose all COBRA continuation rights, if applicable. (See “Appendix E: Continuing Coverage Under COBRA.”) Except in cases of misrepresentation or fraud, an ineligible dependent’s coverage ends at the end of the month following the date of the event causing loss of eligibility or the date you notify Team Member Care that your dependent is ineligible, whichever is later.

If you fraudulently enroll an ineligible individual or intentionally misrepresent a material fact regarding an ineligible individual, coverage will be terminated retroactively to the last day of the month in which eligibility is lost, in accordance with notice provided by the plan administrator. You may be required to repay all costs incurred by the plan, and it may be grounds for corrective action, including termination of your employment. In addition, your dependents may lose the right to continue coverage under COBRA.

Dependent eligibility
For the medical, dental, and vision benefit options, and the Life Insurance, AD&D, and Legal Services Plans, eligible dependents include:

<table>
<thead>
<tr>
<th>Eligible</th>
<th>Not eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your spouse</strong></td>
<td>• Your spouse who is a Wells Fargo team member and is enrolled in Wells Fargo benefits as a team member*</td>
</tr>
<tr>
<td></td>
<td>• Your spouse who is a participant in the Wells Fargo &amp; Company Retiree Plan*</td>
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<tr>
<td></td>
<td>• Your spouse who is covered under a Wells Fargo-sponsored benefit plan as a COBRA participant or a dependent of a COBRA participant</td>
</tr>
<tr>
<td></td>
<td>• Your former spouse from whom you are legally separated or divorced, even if you are court-ordered to provide health insurance</td>
</tr>
<tr>
<td></td>
<td><strong>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</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Your current common-law spouse in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages</strong></td>
</tr>
</tbody>
</table>

* This does not apply to the Life Insurance Plan.
### Eligible

**Your domestic partner**
- Your current same- or opposite-sex domestic partner to whom you are joined in a civil union (or other similar formal relationship) that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the union was created, but is not denominated or recognized as a marriage under the laws of that state or country
- Your current same- or opposite-sex domestic partner with whom you share a domestic partnership (or other similar formal relationship) that is registered by a city, county, state, or country, but is not denominated or recognized as a marriage under the laws of that city, county, state, or country
- Your current same- or opposite-sex domestic partner, if both of you meet all of the following requirements:
  - You and your domestic partner have shared a single, intimate, committed relationship of mutual caring for at least six months and intend to remain in the relationship indefinitely
  - You reside together in the same residence and have lived in a spouse-like relationship for at least six months
  - 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 interdependent, jointly responsible for each other’s basic living expenses, and if asked, are able to provide documentation for three of the following:
    - Joint ownership of real property or a common leasehold interest in real property
    - Common ownership of an automobile
    - Joint bank or credit accounts
    - A will that designates the other as primary beneficiary
    - A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other
    - Designation of one partner as holding power of attorney for health care decisions for the other

### Not eligible

- Your domestic partner who is a Wells Fargo team member and is covered by Wells Fargo benefits as a team member*
- Your domestic partner who is a participant in the Wells Fargo & Company Retiree Plan*
- Your domestic partner who is covered under a Wells Fargo-sponsored benefit plan as a COBRA participant or a dependent of a COBRA participant
- Your former same- or opposite-sex domestic partner from whom you are now separated or the union, domestic partnership, or other recognized formal relationship has been dissolved, even if you are court-ordered to provide health insurance

* This does not apply to the Life Insurance Plan.
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, your spouse’s, or your domestic partner’s naturally born or legally adopted child
  - A child who has been placed with you, your spouse, or your 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, your spouse, or your 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 one of the above eligibility criteria, is age 26 or older, and is incapacitated (see the “Incapacitated children” section starting on this page)

- A child who is enrolled under a Wells Fargo-sponsored benefit plan as a dependent of another team member,* 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 children” section starting on this page)

* This does not apply to the Life Insurance Plan.

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**Legal guardian, legal custodian, and foster children**

Legal guardian, legal custodian, and foster children (court- or agency-appointed) are eligible for coverage until their 26th birthday as long as you, your spouse, or your domestic partner remains the court- or agency-appointed legal guardian, legal custodian, or foster parent. They are eligible to be enrolled within 60 days of the date that their legal guardianship or legal custody arrangement is finalized or within 60 days of the date that their foster child placement is finalized. Enrollment cannot be done online and must be completed by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2. You will be asked to provide a copy of the court- or agency-appointed legal guardianship, legal custodianship, or foster child placement documentation to verify your dependent’s eligibility at the time of enrollment.

**Incapacitated children**

Coverage is also available for your, your spouse’s, or your domestic partner’s naturally born child, legally adopted child, or court- or agency-appointed foster child, or a child for whom you, your spouse, or your domestic partner is the court- or agency-appointed legal guardian or legal custodian, if the child is past his or her 26th birthday, is unmarried, was disabled before his or her 26th birthday, and has been continually covered as an eligible dependent under a Wells Fargo or other health plan since becoming disabled.

Enrollment of incapacitated children can only be done upon the occurrence of one of the following:

- Within 60 days of 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 team members
- During Wells Fargo’s Annual Benefits Enrollment
- Within 60 days of an applicable Qualified Event

Enrollment cannot be done online and must be completed by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, and returning the Incapacitated Dependent Child Statement form as requested.

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:

- Incapable of self-support and unable to carry out the routine functions of daily living without assistance, including but not limited to help with walking, getting into and out of bed, dressing, eating, and other personal functions
- Claimed as your tax dependent on your federal income tax filing for the preceding tax year
Imputed income

If you cover an eligible incapacitated child who is not your tax dependent and you receive a company contribution for medical, dental, or vision coverage, the portion of the company’s contribution 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 income tax purposes, if applicable). As a result, you will receive documentation to account for the applicable amount of imputed income.

Federal and state tax laws may differ, so it is important that you consult your tax advisor. Wells Fargo, the plan administrator, benefit plans, and Team Member Care (formerly known as the HR Service Center) cannot provide tax advice to you.

Ineligible dependents

In addition to those listed as ineligible in the “Dependent eligibility” table starting on page 1-5, 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, or any other event that results in a loss of eligibility), you must notify Team Member Care (formerly known as the HR Service Center) within 60 days of the date your dependent no longer meets the dependent eligibility requirements to drop his or her coverage. If your coverage is COBRA continuation coverage, refer to “Appendix E: Continuing Coverage Under COBRA” for information on dropping your ineligible dependent. If you wait longer than 60 days after the date your dependent no longer meets the dependent eligibility requirements to notify Team Member Care, your dependent may lose all COBRA continuation rights, if applicable. (See “Appendix E: Continuing Coverage Under COBRA.”) Note: Team Member 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). The child will be deemed ineligible and will be dropped from the applicable medical, dental, and vision coverage at the end of the month in which he or she turns age 26, regardless of any separate notification requirements for which you are responsible.

Except in cases of misrepresentation or fraud, an ineligible dependent’s coverage ends at the end of the month following the date of the event causing loss of eligibility, or the date you notify Team Member Care (formerly known as the HR Service Center) that your dependent is ineligible, whichever is later. You may be required to repay the plan for any claims paid by the plan that were incurred after the coverage termination date.

If you fraudulently enroll an ineligible individual or intentionally misrepresent a material fact regarding an ineligible individual, coverage will be terminated retroactively to the last day of the month in which eligibility is lost, in accordance with notice provided by the plan administrator. You may be required to repay all costs incurred by the plan, and it may be grounds for corrective action, including termination of your employment. In addition, your dependents may lose the right to continue coverage under COBRA.

Audits of dependent eligibility

The plan administrator (or its designee), the plans, the applicable claims administrators, the HMOs, and other insurers reserve the right to conduct audits and reviews of all dependent eligibility. You may be asked to provide documentation to verify your dependents’ eligibility at any time. If you fraudulently enroll an ineligible individual or intentionally misrepresent a material fact regarding an ineligible individual, coverage will be terminated retroactively to the last day of the month in which eligibility is lost, in accordance with notice provided by the plan administrator. You may be required to repay all costs incurred by the plan, and it may be grounds for corrective action, including termination of your employment. In addition, your dependents may lose the right to continue coverage under COBRA.
Qualified Medical Child Support Orders —
information for Wells Fargo team members

A Qualified Medical Child Support Order (QMCSO) is a court order that gives an alternate recipient the right to enroll in your group health coverage. If you are 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 group health plans. 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.

The plan administrator delegates Wells Fargo Talent Services-Benefits Operations to receive and process the orders. When Wells Fargo Talent Services-Benefits Operations receives an order, a representative reviews it to ensure that it is qualified and meets all requirements of QMCSOs, 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 specifically names Wells Fargo as the employer and plan sponsor of the group health plan option covering you.
- 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 an official of a state or political subdivision for the mailing address of an alternate recipient; alternatively, the order may also provide the address for a custodial parent or guardian).
  - You (the plan participant) are identified, including your name and last-known mailing address.
  - A reasonable description of the coverage that is to be provided to each alternate recipient.
  - Period to which the order applies.
  - Any restrictions on amounts of premium payments.

Child Support Agencies or a court should submit orders or National Medical Support Notices to:

Wells Fargo Talent Services-Benefits Operations
MAC N9310-117, QMCSO Processing
550 S. 4th Street
Minneapolis, MN 55415

If the order or notice is 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 team member who has not yet satisfied the required waiting period, the team member and child will be enrolled the first of the month following one full calendar month of service with Wells Fargo.

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

Additional key points about QMCSOs:
- Wells Fargo Talent Services-Benefits Operations receives the order or notice directly from the issuing court or agency — it would never come directly from you.
- 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 must meet the plan definition of eligible dependent child.
- If you are eligible for but have not enrolled in a Wells Fargo-sponsored group health plan, you and the child will be enrolled in the plans in which the child is required to be enrolled. You cannot choose to enroll only your child — you must also be enrolled — because the Health Plan allows coverage for dependents only when the team member participates in the Health Plan. Unless the agency specifies another medical, dental, or vision benefit option, you and the alternate recipient (the child) will be enrolled in the HRA-Based Medical Plan, the Delta Dental Standard, and the VSP vision benefit options. Wells Fargo Talent Services-Benefits Operations will notify you of the benefit plan options that you and the alternate recipient (the child) were enrolled in. You will have 60 days from the date of this notification to call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, to request a change in your medical or dental plan option. Changes will be effective the first of the month following your call to Team Member 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 court has not identified another medical plan option, you and the child will be enrolled in the HRA-Based Medical Plan, which is available in all states except Hawaii.
You cannot drop coverage, including coverage for an alternate recipient, while a QMCSO is in force.

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 calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2.

If Wells Fargo Talent Services—Benefits Operations receives a QMCSO termination notice from the issuing court or agency, you will be notified that you are no longer required to enroll the child or children named in the termination notice. You may drop coverage for the child or children named in the termination notice, but only for coverage addressed in the original QMCSO that is the subject of the termination notice, by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days from the date on the notice. Coverage would be dropped the first of the month following your call.

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

Cost and funding

Refer to Teamworks to determine the cost of the coverage you elect. Your contribution or premium is deducted each pay period during which you are enrolled and are receiving pay.

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

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

For other benefit plans and options, see the applicable chapter in this Benefits Book.

In addition, contributions and premiums differ between regular and part-time team members. Any change in contribution or premium due to a change in status from regular to part-time or vice versa becomes effective on the first payroll period after an employment classification change is processed on the payroll system. Per-pay-period premiums and cost for coverage are not prorated.

If your pay is not sufficient to cover your costs for your benefit elections, you are still responsible for your contribution or premiums for coverage. Pay adjustments may be allowed to account for retroactive contributions or premiums from future pay. In some cases, you may be set up on a direct billing process to pay your required contributions and premiums on an after-tax basis.

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

Before-tax contributions

Team member contributions for coverage under certain benefit plans are generally deducted from your pay on a before-tax basis, which may lower your taxable income. There are certain exceptions that are listed below.

Before-tax contributions are governed by the Wells Fargo & Company Flexible Benefits Plan, which has been established as a “cafeteria plan” pursuant to Section 125 of the Internal Revenue Code. The benefit options for which your contributions or premiums are generally made on a before-tax basis are medical, dental, and vision coverage under the Wells Fargo & Company Health Plan; medical coverage under the Wells Fargo & Company International Plan (if applicable); the Full-Purpose Health Care Flexible Spending Account; the Limited Dental/Vision Flexible Spending Account; and the Day Care Flexible Spending Account. Exceptions:

- If you cover a domestic partner or their eligible children, your contributions or premiums for those individuals may not be before-tax, and Wells Fargo’s contribution toward the cost of coverage for your domestic partner and their eligible children may be considered taxable income to you; see the “Tax implications for domestic partners” section on page 1-11 and consult your tax advisor.

- If you are a rehired retiree, your cost for medical, dental, and vision coverage under the Wells Fargo & Company Health Plan (or the Wells Fargo & Company International Plan if applicable) will be on an after-tax basis from your date of rehire until the first of the month following one full calendar month of service with Wells Fargo. For example, if you are rehired on February 23, your contributions for your benefit elections will be on an after-tax basis through March 31. Effective April, your contributions for your benefit elections will be on a before-tax basis where applicable.
After-tax contributions
Team member premiums for the following benefit options are on an after-tax basis:
- Optional Term Life coverage
- Spouse/Partner Optional Term Life coverage
- Dependent Term Life coverage
- Accidental Death and Dismemberment (AD&D) Plan
- Long-Term Disability Plan — Optional LTD
- Legal Services 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
This information in this section is not intended to provide tax advice. Federal and state tax laws may differ. Consult your tax advisor for information about your specific situation.

Domestic partners
If you elect coverage under the medical, dental, or vision benefit options for your domestic partner or his or her 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 his or her children will be deducted from your pay on an after-tax basis. If your domestic partner or his or her 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 Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, to certify that your domestic partner or his or her children qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable).

Imputed income
Generally, your domestic partner (see the “Dependent eligibility” table starting on page 1-5 for domestic partner criteria) and his or her 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 Social Security and Medicare taxes. As a result, you will receive a W-2 to account for the applicable amount of imputed income.

Qualified dependents under the Internal Revenue Code or state tax law
In certain instances, a domestic partner or his or her children may qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable). Discuss this situation with your tax advisor to determine whether your domestic partner and his or her children may qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable). If, after discussing this matter with your tax advisor, you determine that your domestic partner and his or her children qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable), call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, to certify that your domestic partner or his or her children qualify as your dependents under the Internal Revenue Code (or state income tax law, if applicable).

Federal and state tax laws may differ, so it is very important that you consult your tax advisor. Wells Fargo, the plan administrator, benefit plans, and Wells Fargo Team Member Care (formerly known as the HR Service Center) cannot provide tax advice to you.

How benefits are funded
All team member 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. Premiums for HMO or other fully insured coverage may be deposited into a trust fund or paid to the respective HMO or insurer. Claims and expenses associated with benefits provided by the HMO or insurer are paid for by the HMO or insurer.

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. Nothing requires that amounts deposited to a trust fund be held separately or used for a particular benefit option, including the benefit option for which the amount was deposited. No team member, former team member, 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 team member and are held as general assets of Wells Fargo.

The total cost of benefits and administration of the Short-Term Disability Plan are paid from the general assets of Wells Fargo. There is no insurance contract for the plan, and the claims administrator functions as a plan service provider and not as an insurer.

Benefits under the Salary Continuation Pay Plan are currently paid from the general assets of Wells Fargo.

How to enroll

Initial enrollment

If you are or become a benefits-eligible regular or part-time team member, you are automatically enrolled in the following company-paid benefit options:

- Basic Term Life coverage portion of the Life Insurance Plan
- Business Travel Accident (BTA) Plan
- Short-Term Disability (STD) Plan
- Long-Term Disability (LTD) Plan – Basic LTD
- Salary Continuation Pay Plan

You may enroll in certain other benefit plans and corresponding benefit options during the designated enrollment period by accessing the benefits enrollment site on Teamworks, or by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, if you do not have online access at work or at home. A Benefits Enrollment Kit will be sent to you with additional information about initial enrollment. If you have not received the Benefits Enrollment Kit within 15 days of your new hire date or the date your employment classification changed making you newly eligible for benefits, call Team Member Care.

During your designated enrollment period, eligible team members may be able 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
- Optional Term Life
- Spouse/Partner Optional Term Life
- Dependent Term Life
- Accidental Death and Dismemberment (AD&D)
- Optional Long-Term Disability (LTD)
- Legal Services Plan

The “When to enroll — when benefits take effect” section on page 1-13 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 benefits coverage. If you want to cover eligible dependents (including a spouse or domestic partner), you must enroll them during your designated enrollment period. (By enrolling a dependent, you are certifying that your dependent meets the stated eligibility requirements; see the “Eligible dependents” section starting on page 1-5.) Your designated enrollment period begins on the date you are hired, rehired, or become newly eligible for benefits and runs through the date listed in the table on page 1-14.

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 team member paid on the Wells Fargo U.S. payroll system as a benefits-eligible regular or part-time team member, you will be contacted by Team Member Care (formerly known as the HR Service Center) to review your applicable benefit plan and enrollment options. Team Member Care will coordinate your enrollment period and process your benefit elections.

Note: If you want to cover an eligible incapacitated dependent, enrollment cannot be done online and must be completed by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, within your designated enrollment period and returning a form.

If you do not enroll during your designated enrollment period, you may do so during your change period, which ends the day before your benefits take effect. If you do not enroll during your designated enrollment period or change period, 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. See the “Changing coverage” section starting on page 1-18. 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 proof of good health or evidence of insurability process. See the Life Insurance Plan and Long-Term Disability Plan chapters in this Benefits Book for more information.

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

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

If you become eligible to enroll in the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance, you will receive enrollment materials that provide information about the initial enrollment process, the due date to complete enrollment, and the applicable effective date of coverage. You will not have another opportunity to enroll in benefits until the next Annual Benefits Enrollment period for this plan unless you experience an event that would allow you to enroll outside of the initial designated enrollment period for this plan. See the “Changing coverage” section starting on page 1-18.

**When to enroll — when benefits take effect**

You must enroll during your initial designated enrollment period based on your hire or eligibility date as noted in the table on page 1-14. For most benefit plans, coverage becomes effective the first of the month following one full calendar month of service with Wells Fargo in a benefits-eligible position if you enroll during your initial designated enrollment period, with the following exceptions:

- 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, and the Optional Term Life Insurance coverage is delayed until you return to work (you must return to work in a benefits-eligible position).

- Rehired retirees (see the “Rehired retirees” section on page 1-15).

- For the effective date under the Salary Continuation Pay Plan, refer to “Chapter 12: Salary Continuation Pay Plan.”

- The effective date of coverage under the Wells Fargo & Company International Plan will be communicated to you in the enrollment materials you receive when you become eligible for the plan. Generally, coverage becomes effective the first of the month after the effective date of the applicable international assignment agreement (if the effective date of the agreement is the first of the month, coverage is effective the first of that month) provided that the required enrollment paperwork has been submitted by the due date and you have been in a benefits-eligible position for one full calendar month.

- If you are already working for Wells Fargo as a local hire on local payroll (other than U.S. payroll) and you become a localized U.S.-based team member paid on the Wells Fargo U.S. payroll system as a benefits-eligible regular or part-time team member, your coverage under the U.S. benefits as a team member becomes effective the first of the month following the date you become a localized U.S.-based team member. But, if you become a U.S.-based team member on the first of the month, your benefits will become effective that day. However, if you are not actively at work on the date coverage would normally begin, your effective date for BTA, AD&D, STD, Basic LTD, Optional LTD, Basic Term Life, and the Optional Term Life Insurance coverage is delayed until you return to work on U.S. payroll (you must return to work in a benefits-eligible position).

- If you were covered under the Wells Fargo & Company International Plan and your international assignment ends, you will be contacted by Team Member Care (formerly known as the HR Service Center) to discuss your medical plan options under the Wells Fargo & Company Health Plan. Your medical coverage under the Health Plan becomes effective the first of the month following the date your international assignment ended.

- For the enrollment period and effective date of COBRA continuation coverage, refer to “Appendix E: Continuing Coverage Under COBRA.”
If you are hired or rehired or become newly eligible:

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<th>End Date</th>
<th>Enrollment Date</th>
<th>Effect Date</th>
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<td>March 1</td>
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Benefits Confirmation Statement and corrections

You will receive a Benefits Confirmation Statement for review soon after you have made your new hire or newly eligible benefit enrollment elections. If you are provided an electronic copy of the Benefits Confirmation Statement by email (or similar electronic delivery), you may print a copy for your records. You also have the right to request that a paper copy of your Benefits Confirmation Statement be sent to you, at no cost. You may request a paper copy of your Benefits Confirmation Statement either by sending an email to hrsddistributionfulfillment@wellsfargo.com or by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2. If the Benefits Confirmation Statement does not match the elections you made, you can make corrections or changes up until the last day of the month before the month in which the benefits will become effective.

You may make corrections or changes using the benefits enrollment website or by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2. No changes can be made to your enrollment after your benefits become effective. However, you may be able to change coverage elections at a later date if you experience a Qualified Event or special enrollment event; see the “Changing coverage” section starting on page 1-18.

Requests for enrollment and eligibility review

The Wells Fargo-sponsored employee benefit plans must adhere to the enrollment election restrictions in order to remain in compliance with regulations that govern the plans.

If you believe you have experienced extraordinary circumstances that caused you or your dependents to miss enrollment, erroneously be enrolled in benefits, or have benefits terminated in error, call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, to request a review of your situation. If you are dissatisfied with the determination, you may submit a written request for a review of your situation to Corporate Benefits, on behalf of the plan administrator, at the following address:

Corporate Benefits
Wells Fargo & Company
MAC Ng310-110
550 S. 4th Street
Minneapolis, MN 55415
Corporate Benefits cannot accept requests sent by fax or email. Before you send a request to Corporate Benefits for review, Team Member Care (formerly known as the HR Service Center) must have already reviewed your request. Corporate Benefits must receive your written request for review within 120 days of the event that would have allowed or changed enrollment. 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 eligibility for enrollment in the respective plans, subject to the terms of applicable plan documents. Inquiries regarding eligibility and enrollment that are within the plan administrator’s authority generally are not subject to claims and appeals procedures. Eligibility and enrollment decisions made by Corporate Benefits, on behalf of the plan administrator, are conclusive and binding on all parties and are not subject to further review.

**When coverage begins**

The medical, dental, and vision benefit options have no preexisting condition exclusions.

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

**New or newly eligible team members**

If you enroll in benefits during your designated enrollment period, coverage for most plans begins the first of the month after one full calendar month of service in a benefits-eligible position, except as noted in the “When to enroll — when benefits take effect” section on page 1-13. For eligible dependents enrolled during your initial designated enrollment period, their coverage begins when your coverage begins.

**Rehired team members**

If you were previously employed by Wells Fargo & Company or any of its subsidiaries or affiliates, your employment was terminated, and you are rehired as a regular or part-time team member, your benefits enrollment and coverage effective date are handled like a new team member. See the “New or newly eligible team members” section on this page.

**Rehired retirees**

If you are a retiree who has coverage under the Wells Fargo & Company Retiree Plan (Retiree Plan) and you are rehired as a benefits-eligible regular or part-time team member, 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. Upon rehire, you will be contacted by Team Member Care (formerly known as the HR Service Center) to review your enrollment options. Generally, your coverage as a team member becomes effective on your date of rehire. However, your participation in a Full-Purpose Health Care Flexible Spending Account, Limited Dental/Vision Flexible Spending Account, or the Day Care Flexible Spending Account begins the first of the month following one full calendar month of service. For example, if you are rehired on February 23, your participation in the applicable flexible spending account begins on April 1.

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, and the Optional Term Life Insurance coverage is delayed until you return to work (you must return to work in a benefits-eligible position).

If you are a retiree who is rehired as a flexible team member, you are not eligible to enroll in benefits as a team member. You will also not be eligible to continue your retiree health care coverage under the Retiree Plan. Retiree coverage terminates the day before your rehire date.

Note: For details regarding your medical coverage upon rehire, refer to the Wells Fargo & Company Retiree Plan Summary Plan Description, which is contained in the Retiree Benefits Book.

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 Summary Plan Description of the Retiree Life Insurance Plan). 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.

**Enrollment election changes**

See the “Changing coverage” section starting on page 1-18.

**COBRA continuation coverage**

Refer to “Appendix E: Continuing Coverage Under COBRA” for information on when coverage becomes effective.
Coordination with other coverage

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

Note the following:

- There is no coordination of benefits between benefit plan options under Wells Fargo-sponsored group health plans. Only one benefit option under a Wells Fargo-sponsored group health plan will provide coverage for eligible expenses. For example, you cannot receive benefits under the Health Plan from both a medical plan option and the dental plan option for the same services.

- Wells Fargo medical plan options do not coordinate prescription drug benefits. For example, if you are covered under a Wells Fargo medical plan option and another plan is primary, there is no secondary prescription drug benefit under the Wells Fargo medical plan option.

- See “Chapter 3: Dental Plan” in this Benefits Book for information on coordination of benefits under the dental plan benefit option.

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

If the applicable Wells Fargo-sponsored group health plan is secondary, it pays only the difference between the other plan’s benefit, if lower, and the normal Wells Fargo-sponsored group health plan benefit. When the primary plan pays a benefit that equals or exceeds the normal Wells Fargo-sponsored group health plan benefit, the Wells Fargo-sponsored group health plan pays nothing.

If you receive benefits from more than one group health plan (or a government-supported program other than Medicaid), the primary payer must process your claim before you can submit it to the secondary payer.

If you are not covered under Medicare, the following rules determine the order of plan payment:

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 the longest is the primary plan.
   d. If a part-time 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 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 team members with a currently active employment status. The medical plan coverage under the Wells Fargo & Company Health Plan will pay benefits secondary to Medicare to the extent permitted by federal law, including the MSP rules. **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 are eligible for 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, 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, claims with dates of service after the 30-month coordination period will be denied. 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 eligible for Medicare at the time you enroll in continuation coverage under COBRA, Medicare is primary, to the extent permitted by federal law. There is no reduction in the COBRA premiums for the COBRA continuation 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.

**Important information for team members 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 his or her Medicare “Initial Enrollment Period,” your domestic partner may be subject to late enrollment penalties or surcharges imposed by Medicare on late enrollees. Medicare late enrollment penalties could apply even if your domestic partner is covered as your dependent under the Wells Fargo & Company Health Plan. 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, Team Member Care (formerly known as the HR Service Center), 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

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

- A qualified change in status affects your or your dependents’ eligibility under the plan.
- You or your eligible dependent experiences an event that qualifies as a special enrollment right.

If you enroll a dependent (including your spouse or domestic partner) as a result of a change in your benefit elections, you are certifying that your dependent meets the stated dependent eligibility requirements; see the “Eligible dependents” section starting on page 1-5.

Changes are restricted

Unless you experience a Qualified Event or special enrollment event, your ability to make changes to your benefit elections or coverage level is restricted, except during the Annual Benefits Enrollment period for benefits effective the next plan year. This means that after you enroll, you cannot cancel or modify your benefit elections during the plan year unless you experience a Qualified Event or become entitled to special enrollment rights. To understand what benefit election changes you can make during the year as a result of a Qualified Event, see the “Qualified Events” table starting on page 1-22, and the “Special enrollment rights” section starting on page 1-20.

If you have questions about changing or adding coverage, call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2. If your coverage is COBRA continuation coverage, refer to “Appendix E: Continuing Coverage Under COBRA” for contact information.

Changes must be consistent

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 plan’s medical coverage. The plan administrator has sole discretion to determine whether a requested change is a result of and corresponds to a Qualified Event.

Limited time to make changes

You can only make changes to your benefit elections during certain periods:

- During the published Annual Benefits Enrollment period
- Within 60 days of the date of an event listed in the “Qualified Events” table starting on page 1-24
- Within 60 days of the date of a special enrollment event as noted in the “Special enrollment rights” section starting on page 1-20

You may also call Team Member Care (formerly known as the HR Service Center) up to 30 days before certain Qualified Events or if you or your eligible dependent experiences an event that qualifies as a special enrollment right (for example, marriage) to make a change to your benefit elections. If the future event does not take place as expected, you must call Team Member Care to cancel your benefit election change.

Enrolling a newborn or newly adopted child

Please note that your new child can be added to your benefits only by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days of your child’s birth, adoption, or placement for adoption. (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. You must call Team Member Care within 60 days of your child’s birth, adoption, or placement for adoption. However, enrollment in any other benefit plans or corresponding benefit option due to a Qualified Event of birth or adoption of a child will be effective as of the date of birth, adoption, or placement for adoption. For additional information, see the Qualified Event for “Birth or adoption of a child” on page 1-26.

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 team member’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 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 a team member with medical coverage for himself 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 his 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 a team member covering one child is January 22.

**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 do not make changes during Annual Benefits Enrollment, your enrollment in the benefit plans and benefit options other than the Full-Purpose Health Care Flexible Spending Account, the Limited Dental/Vision Flexible Spending Account, or the Day Care Flexible Spending Account will 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 do not provide certification or proof of your dependents’ eligibility when requested.

You 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 Annual Benefits Enrollment information by November 1, call Team Member Care (formerly known as the HR Service Center) 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 1-877-39-COBRA (26272).

**Effective date**

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

**If you move**

If you’re planning to move (a change in your permanent residential address), you should call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, to speak with a representative as soon as you know your new address to update the plan administrator’s record of 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 United States or its territories (Puerto Rico, Guam, or Northern Mariana Islands (Saipan)), 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 United States and you are on international assignment, you may be eligible for the Wells Fargo & Company International Plan (see the “Additional requirements for the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance” section on page 1-4).
• If your covered spouse or dependent moves, making him or her 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 to request a change to your medical plan benefit option, if applicable. If you do not request a change and your current medical plan benefit option is not available in your new location, you will automatically be enrolled in the HRA-Based Medical Plan at your existing level of coverage. However, if you were enrolled in a High-Deductible Health Plan (HDHP) — Kaiser medical plan and that plan is not available in your new location, you will automatically be enrolled in the HSA-Based Medical Plan – Gold at your existing level of coverage. And, if your move is to Puerto Rico, Guam, or Northern Mariana Islands (Saipan), you will automatically be enrolled in the Indemnity Medical Plan — Anthem BCBS at your existing level of coverage. But, if your change in permanent residence is outside the United States or its territories (Puerto Rico, Guam, or Northern Mariana Islands (Saipan)), 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 United States and you are on international assignment, you may be eligible for the Wells Fargo & Company International Plan (see the “Additional requirements for the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance” section on page 1-4).

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 Team Member Care (formerly known as the HR Service Center), 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 Team Member Care, whichever is later. If the date of your move is the first of the month and you call Team Member Care 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 moved on August 1, and you call Team Member Care (formerly known as the HR Service Center) 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
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 annual or initial enrollment. Special enrollment rights only apply if the individual was actually enrolled in other medical coverage. The following special enrollment events are available to active benefits-eligible team members.

You may enroll yourself and any of your eligible dependents (see the “Eligible dependents” section starting on page 1-5) in an available medical plan benefit option if:

• You are benefits-eligible 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 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)
    ◦ 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 his or her eligible children’s) health coverage through his or her employer due to:
° Loss of eligibility
° Exhaustion of coverage because the employer stopped making contributions toward other 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 his or her 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 his or her children) becomes eligible for premium assistance under Medicaid or CHIP
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 his or her employer resulting from a loss of eligibility, you may enroll your spouse or domestic partner in a medical plan benefit option under the Wells Fargo & Company Health Plan (or the Wells Fargo & Company International Plan, if applicable). However, special enrollment rights do not allow you to make an election to enroll in any other benefit plan or benefit option.
When you, the team member, have lost eligibility for other medical coverage for reasons other than 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, you may enroll in medical coverage at Wells Fargo. You may also enroll any other eligible dependents (see the “Eligible dependents” section starting on page 1-5), including your spouse or domestic partner. When one of your dependents, including a spouse or domestic partner, has lost eligibility for other medical coverage for reasons other than 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, you may enroll the eligible dependent (who has lost other coverage) in medical coverage at Wells Fargo. If you are not currently enrolled in medical coverage, you must also enroll. You may also enroll any other eligible dependents, including your spouse or domestic partner, in medical coverage at this time.
You must enroll in or add eligible dependents to medical coverage within 60 days of the date of the special enrollment event by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2. If your coverage is COBRA continuation coverage, refer to “Appendix E: Continuing Coverage Under COBRA” for information on changing your benefit elections due to a special enrollment event.
You may also call Team Member Care (formerly known as the HR Service Center) 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. If the future event does not take place as expected, you must call Team Member Care to cancel your enrollment in or addition of eligible dependents to medical coverage.
After the 60-day enrollment period expires, you cannot enroll in or add new dependents to medical coverage. Unless you or your eligible dependents experience a Qualified Event or an event resulting in a special enrollment right, you will be required to wait until the next Annual Benefits Enrollment period to enroll in or add your dependents to coverage.
After you make an election or change due to a special enrollment right, you may not make further changes to that benefit election during the 60-day enrollment period unless you experience another special enrollment event or Qualified Event.
Effective date
Coverage, as a result of special enrollment rights, and the corresponding cost for coverage will generally be effective the first of the month following the date of the event or the first of the month following the date you call Team Member Care (formerly known as the HR Service Center), 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 for 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

A Qualified Event is an event listed in the “Qualified Events” table starting on page 1-24 that results in gain or loss of eligibility for coverage by you, your spouse or domestic partner, or your dependents. However, any changes in coverage must be consistent with the Qualified Event. For example, you cannot cancel coverage for an individual who has become eligible for coverage under another plan unless that individual actually becomes covered under the other 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 call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days of the date of the applicable event listed in the “Qualified Events” table starting on page 1-24. 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.

You may also call Team Member Care (formerly known as the HR Service Center) 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 Team Member Care to cancel your benefit election change.

After you make an election change due to a Qualified Event, you may not make further 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 results in enrolling a dependent (including your spouse or domestic partner), by enrolling that dependent, you are certifying that your dependent meets the stated eligibility requirements; see the “Eligible dependents” section starting on page 1-5.

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 call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days of the date of marriage to request the change. If you fail to call Team Member Care to request 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 1-24.

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 call Team Member Care (formerly known as the HR Service Center), 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 benefits coverage, most benefit plans coverage becomes effective the first of the month following one full calendar month of service with Wells Fargo in a benefits-eligible position, if you enroll during your designated enrollment period. For additional information, see the “When to enroll — when benefits take effect” section on page 1-13.
• 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 you call Team Member Care (formerly known as the HR Service Center) on July 25 and request 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 also 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 call Team Member Care to add your child.

• If the event date is the first of the month and you call Team Member Care (formerly known as the HR Service Center) 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 call Team Member Care on July 25 and request 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 notify Team Member Care (formerly known as the HR Service Center) that the dependent is ineligible. 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.
Marriage or formation of domestic partnership — change in the number of the team member’s eligible dependents

What benefit election changes can you make when you get married or form a domestic partnership?

### Medical, Dental, or Vision

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 his or her 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 his or her 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.*

You may change medical plans if:
- You add your newly eligible spouse or his or her 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*

You 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.

You 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 his or her employer’s plan

### Legal Services

You may enroll, increase, decrease, or drop coverage.

### Life Insurance, AD&D, and Disability Plans

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 team member’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?**

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Changes Allowed</th>
</tr>
</thead>
</table>
| **Medical, Dental, or Vision** | You must drop your former spouse or former domestic partner and, unless a court or other appropriate government entity issues a qualified medical child support order (QMCSO) requiring you to maintain coverage, any dependents of your former spouse or domestic partner who are not also your dependents.  
You may enroll or add:  
- Yourself if you lose the same type of coverage under your former spouse’s or domestic partner’s employer’s plan  
- Your eligible dependent children if they lose the same type of coverage under your former spouse’s or domestic partner’s employer’s plan  
- Your previously eligible dependent children only if you newly enroll yourself or you enroll an eligible dependent child who lost the same type of coverage under your former spouse’s or domestic partner’s employer’s plan  
**Reminder:** If you want to enroll your eligible dependent children, you must also enroll or be enrolled.  
You may not drop coverage for yourself or other covered eligible dependents.  
You may change benefit options if you add coverage for your eligible dependent children. |
| **Full-Purpose Health Care FSA* and Limited Dental/Vision FSA*** | You 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*** | You 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** | You may enroll, increase, decrease, or drop coverage. |
| **Life Insurance, AD&D, and Disability Plans** | Refer to the applicable chapter in this *Benefits Book* for information on allowed election changes. |

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*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 team member’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, or if you or your spouse or domestic partner has been newly identified as the father of a child.

<table>
<thead>
<tr>
<th>Medical, Dental, or Vision</th>
<th>You may enroll or add:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Yourself if you are the biological or adopting parent</td>
</tr>
<tr>
<td></td>
<td>• Your spouse (for situations where the team member and spouse are the birth or adopting parents)</td>
</tr>
<tr>
<td></td>
<td>• Your spouse only if you add your newly eligible child (for situations where the team member or spouse are the newly appointed legal guardian, legal custodian, or foster parent)</td>
</tr>
<tr>
<td></td>
<td>• The newly eligible child</td>
</tr>
<tr>
<td></td>
<td>• Your previously eligible dependent children only if you newly enroll yourself, or add your spouse or the newly eligible child</td>
</tr>
<tr>
<td></td>
<td>• Your domestic partner or your domestic partner’s eligible dependent children if you add your newly eligible child (for situations where the team member and the domestic partner are the biological or adoptive parents)</td>
</tr>
<tr>
<td></td>
<td>• 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 team member is the newly appointed legal guardian, legal custodian, or foster parent)</td>
</tr>
<tr>
<td></td>
<td>• 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)</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>You may drop:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Yourself only if you enroll in the same type of coverage under your spouse’s employer’s plan (excludes domestic partnerships)</td>
</tr>
<tr>
<td>• 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)</td>
</tr>
<tr>
<td>• 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</td>
</tr>
<tr>
<td>• Your domestic partner’s or his or her child’s existing coverage if he or she enrolls in the same type of coverage under your domestic partner’s employer’s plan</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>You may change benefit options if:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You enroll or add coverage for your newly eligible child or your spouse (for situations where the team member or the spouse is the biological or adoptive parent)</td>
</tr>
<tr>
<td>• 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</td>
</tr>
</tbody>
</table>
### Full-Purpose Health Care FSA* and Limited Dental/Vision FSA*

You 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*

**You may** enroll your FSA election.

### Legal Services

**You may** enroll, increase, decrease, or drop coverage.

### Life Insurance, AD&D, and Disability Plans

Refer to the applicable chapter in this *Benefits Book* for information on allowed election changes.

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* 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.

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### 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)?

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical, Dental, or Vision</td>
<td><strong>You must</strong> drop coverage only for the dependent who loses eligibility.</td>
</tr>
<tr>
<td></td>
<td><em>Reminder: You may not drop coverage for yourself or any other enrolled dependents.</em></td>
</tr>
<tr>
<td></td>
<td><strong>You may not</strong> change benefit options with this event.</td>
</tr>
<tr>
<td>Full-Purpose Health Care FSA*</td>
<td><strong>You may</strong> drop or decrease your FSA election.</td>
</tr>
<tr>
<td>and Limited Dental/Vision FSA*</td>
<td><strong>You may not</strong> change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.</td>
</tr>
<tr>
<td>Day Care FSA*</td>
<td><strong>You may</strong> drop or decrease your FSA election <strong>only if</strong> 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.</td>
</tr>
<tr>
<td>Legal Services</td>
<td><strong>You may</strong> enroll, increase, decrease, or drop coverage.</td>
</tr>
<tr>
<td>Life Insurance, AD&amp;D, and Disability Plans</td>
<td>Refer to the applicable chapter in this <em>Benefits Book</em> for information on allowed election changes.</td>
</tr>
</tbody>
</table>

* You may not make changes to your flexible spending account (FSA) elections if your domestic partner or his or her 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

**What benefit election changes can you make when you have a change in your employment status that affects your eligibility for benefits at Wells Fargo?**

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Medical, Dental, or Vision**                   | If you become newly eligible for benefits, you may enroll or add:  
  • 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 status makes you ineligible for benefits (for example, your employment status changes from regular to flexible status), your coverage (and that of any enrolled dependents, including your spouse or domestic partner) will be dropped automatically. You may have the right to elect continuation coverage under COBRA for you, your spouse, and your eligible dependents. 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.  
  
  *You may not change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.* |
| **Full-Purpose Health Care FSA and Limited Dental/Vision FSA** | If you become newly eligible for benefits, you may enroll.  
  **Automatic drop:** If a change in your employment status makes you ineligible for benefits (for example, your employment status changes from regular to flexible status), 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.  
  
  *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 you become newly eligible for benefits, you may enroll.  
  **Automatic drop:** If a change in your employment status makes you ineligible for benefits (for example, your employment status changes from regular to flexible status), 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 1-33 of this Qualified Events table for information on allowed election changes.  
  
  *You may not change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.* |
| **Legal Services**                                 | You may enroll, increase, decrease, or drop coverage.  
  **Life Insurance, AD&D, and Disability Plans**     | If you become newly eligible for benefits, you 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 a change in your employment status makes you ineligible for benefits (for example, your employment status changes from regular to flexible status), 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. |

* Please note that having a change in status from full-time to part-time 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 for your spouse or domestic partner or dependent child that affects eligibility (becoming newly eligible for benefits through his or her 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?

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Changes You May Make</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical, Dental, or Vision</strong></td>
<td>You may drop:</td>
</tr>
<tr>
<td></td>
<td>• Coverage for yourself if you become enrolled in the same type of coverage through your spouse's employer's plan</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• Coverage for your spouse or domestic partner if he or she becomes enrolled in the same type of coverage through his or her employer’s plan</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td><strong>Reminder:</strong> If you elect to drop your coverage, coverage for any enrolled dependents, including your spouse or domestic partner, will also be dropped.</td>
</tr>
<tr>
<td></td>
<td>You may not drop coverage for yourself if:</td>
</tr>
<tr>
<td></td>
<td>• Your dependent child gets a new job or has a change in employment status</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td><strong>You may not change benefit options with this event.</strong></td>
</tr>
<tr>
<td><em><em>Full-Purpose Health Care FSA</em> and Limited Dental/Vision FSA</em>**</td>
<td>You may drop or decrease your FSA election if you become enrolled in coverage under your spouse's employer's medical plan.</td>
</tr>
<tr>
<td></td>
<td><strong>You may not</strong> change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.</td>
</tr>
<tr>
<td><strong>Day Care FSA</strong></td>
<td>You may:</td>
</tr>
<tr>
<td></td>
<td>• Enroll or increase your contributions if your spouse begins new employment and has not previously been employed</td>
</tr>
<tr>
<td></td>
<td>• Drop or decrease your FSA election if your spouse begins new employment and enrolls in his or her employer's day care FSA (dependent care FSA)</td>
</tr>
<tr>
<td><strong>Legal Services</strong></td>
<td>You may enroll, increase, decrease, or drop coverage.</td>
</tr>
<tr>
<td><strong>Life Insurance, AD&amp;D, and Disability Plans</strong></td>
<td>Refer to the applicable chapter in this Benefits Book for information on allowed election changes.</td>
</tr>
</tbody>
</table>

*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 his or her 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?

<table>
<thead>
<tr>
<th>Benefit Area</th>
<th>Eligibility Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical, Dental, or Vision</strong></td>
<td>- Yourself if you or your dependent has lost the same type of coverage under another employer’s plan</td>
</tr>
<tr>
<td></td>
<td>- Your spouse or domestic partner who has lost the same type of coverage under another employer’s plan</td>
</tr>
<tr>
<td></td>
<td>- Your eligible dependent children who have lost the same type of coverage under another employer’s plan</td>
</tr>
<tr>
<td></td>
<td>- Your other eligible dependent children only if you enroll or add coverage for your eligible dependent child has lost the same type of coverage under another employer’s plan</td>
</tr>
<tr>
<td><strong>Reminder:</strong> If you want to enroll your spouse, domestic partner, or eligible dependent children, you must also enroll or be enrolled.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>You may not drop coverage for yourself, your spouse or domestic partner, or your eligible dependent children.</td>
</tr>
<tr>
<td></td>
<td>You may change plans if you add coverage for your spouse or domestic partner or your eligible dependent children.</td>
</tr>
<tr>
<td><em><em>Full-Purpose Health Care FSA</em> and Limited Dental/Vision FSA</em>**</td>
<td>You may enroll or increase your election if you lost coverage under your spouse’s employer’s medical plan.</td>
</tr>
<tr>
<td></td>
<td>You may not change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.</td>
</tr>
<tr>
<td><strong>Day Care FSA</strong>*</td>
<td>You may:</td>
</tr>
<tr>
<td></td>
<td>- Enroll or increase your FSA election if your spouse loses eligibility under his or her employer’s day care FSA (dependent care FSA) but continues to be employed.</td>
</tr>
<tr>
<td></td>
<td>- Enroll or increase your contributions if your spouse loses eligibility under his or her employer’s day care FSA (dependent care FSA) due to loss of employment. If your spouse is not employed, then he or she needs to meet one of the other criteria detailed in &quot;Chapter 6: Day Care Flexible Spending Account.&quot;</td>
</tr>
<tr>
<td></td>
<td>- 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.</td>
</tr>
<tr>
<td><strong>Legal Services</strong></td>
<td>You may enroll, increase, decrease, or drop coverage.</td>
</tr>
<tr>
<td><strong>Life Insurance, AD&amp;D, and Disability Plans</strong></td>
<td>Refer to the applicable chapter in this Benefits Book for information on allowed election changes.</td>
</tr>
</tbody>
</table>

* 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 his or her 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 his or her employer’s official open enrollment period (this does not include a new hire enrollment period)?**

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Eligibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical, Dental, or Vision</strong></td>
<td>You may enroll or add:</td>
</tr>
<tr>
<td></td>
<td>• Yourself if your same type of coverage is dropped during a spouse’s employer’s plan’s official open enrollment period</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• Your domestic partner or his or her eligible dependent children, to your existing coverage, if your domestic partner or domestic partner’s child drops the same type of coverage during his or her employer’s plan’s official open enrollment period</td>
</tr>
<tr>
<td><strong>You may drop:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Yourself, your spouse, and any covered dependent children who become newly enrolled in the same type of coverage under your spouse’s employer’s plan as a result of his or her election during his or her employer’s plan’s official open enrollment period</td>
</tr>
<tr>
<td></td>
<td>• Your covered dependent child who becomes newly enrolled in the same type of coverage under his or her employer’s plan as a result of his or her election during the employer’s plan’s official open enrollment period</td>
</tr>
<tr>
<td></td>
<td>• Your domestic partner or his or her 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 his or her election during his or her employer’s plan’s official open enrollment period</td>
</tr>
<tr>
<td></td>
<td>• Your domestic partner’s child who becomes newly enrolled in the same type of coverage under his or her employer’s plan as a result of his or her election during the employer’s plan’s official open enrollment period</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Eligibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full-Purpose Health Care FSA</strong></td>
<td>You may not make any changes to your FSA election.</td>
</tr>
<tr>
<td>and Limited Dental/Vision FSA*</td>
<td></td>
</tr>
<tr>
<td><strong>Day Care FSA</strong></td>
<td>You may:</td>
</tr>
<tr>
<td></td>
<td>• Enroll or increase your FSA election if your spouse does not elect to make contributions to his or her employer’s day care FSA (dependent care FSA) during your spouse’s employer’s plan’s official open enrollment period</td>
</tr>
<tr>
<td></td>
<td>• 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)</td>
</tr>
<tr>
<td></td>
<td>• Drop or decrease your FSA election if your spouse elects to make contributions to his or her employer’s day care FSA during the employer’s plan’s official open enrollment period</td>
</tr>
<tr>
<td><strong>Legal Services</strong></td>
<td>You may enroll, increase, decrease, or drop coverage.</td>
</tr>
<tr>
<td><strong>Life Insurance, AD&amp;D, and Disability Plans</strong></td>
<td>Refer to the applicable chapter in this Benefits Book for information on allowed election changes.</td>
</tr>
</tbody>
</table>

*You may not make changes to your flexible spending account (FSA) elections as a result of new coverage elections by your domestic partner or his or her child.*
### Change in place of 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 coverage at Wells Fargo?*

<table>
<thead>
<tr>
<th>Benefit Area</th>
<th>Description</th>
</tr>
</thead>
</table>
| **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 he or she resided outside of the United States (U.S.), when he or she moves 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 to 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 United States or its territories, you are no longer eligible to be enrolled in a medical benefit option and your medical coverage will automatically be dropped. See the “If you move” section starting on page 1-19 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** | See the “Change in day care services or needs” section on page 1-33 of this Qualified Events table. |
| **Legal Services** | You may enroll, increase, decrease, or drop coverage. |
| **Life Insurance, AD&D, and Disability Plans** | 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?*

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical, Dental, or Vision</td>
<td>You may not make changes to your benefit elections.</td>
</tr>
<tr>
<td>Full-Purpose Health Care FSA and Limited Dental/Vision FSA</td>
<td>You may not make changes to your FSA election.</td>
</tr>
<tr>
<td>Day Care FSA</td>
<td>You may:</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• Enroll if you start day care services (for example, as a result of returning to Wells Fargo in a benefits-eligible position after having been on a leave of absence) and will incur qualified day care expenses</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• 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)</td>
</tr>
<tr>
<td>Legal Services</td>
<td>You may not make changes to your benefit election.</td>
</tr>
<tr>
<td>Life Insurance, AD&amp;D, and Disability Plans</td>
<td>Generally, a change in day care needs does not impact these benefits. Refer to the applicable chapter in this <em>Benefits Book</em> for information on allowed election changes.</td>
</tr>
</tbody>
</table>
### 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 his or her 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 changes to your FSA election.

   **Legal Services**  
   You may not make changes to your benefit election.

   **Life Insurance, AD&D, and Disability Plans**  
   A change in entitlement to Medicare or Medicaid does not impact these benefits. 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, and Disability Plans**  
   Enrollment in CHIP does not impact these benefits. 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 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. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Purpose Health Care FSA and Limited Dental/Vision FSA</td>
<td>You may not make changes to your FSA election.</td>
</tr>
<tr>
<td>Day Care FSA</td>
<td>You may not make changes to your FSA election.</td>
</tr>
<tr>
<td>Legal Services</td>
<td>You may not make changes to your benefit election.</td>
</tr>
<tr>
<td>Life Insurance, AD&amp;D, and Disability Plans</td>
<td>Eligibility for a Medicaid or CHIP subsidy does not impact these benefits. Refer to the applicable chapter in this <em>Benefits Book</em> for information on allowed election changes.</td>
</tr>
</tbody>
</table>

### 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. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Purpose Health Care FSA and Limited Dental/Vision FSA</td>
<td>You may enroll or increase your election if you, your spouse, or your eligible dependent children lose eligibility under Medicare. \nYou 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. \nYou may not change your enrollment from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa.</td>
</tr>
<tr>
<td>Day Care FSA</td>
<td>You may not make any changes to your FSA election.</td>
</tr>
<tr>
<td>Legal Services</td>
<td>You may not make changes to your benefit election.</td>
</tr>
<tr>
<td>Life Insurance, AD&amp;D, and Disability Plans</td>
<td>A change in eligibility for Medicare does not impact these benefits. Refer to the applicable chapter in this <em>Benefits Book</em> for information on allowed election changes.</td>
</tr>
</tbody>
</table>
# 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.  
  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 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, and Disability Plans | Loss of coverage under Medicaid or CHIP does not impact these benefits. Refer to the applicable chapter in this *Benefits Book* for information on allowed election changes. |
### Judgments, decrees, or orders — requires a team member 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 Support Order) **requires** you, the team member, to provide coverage for a dependent child?

<table>
<thead>
<tr>
<th>Benefits Plan</th>
<th>Allowable Changes</th>
</tr>
</thead>
</table>
| Medical, Dental, or Vision | 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 team member, 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, or legal custody arrangement, or newly identified paternity requires you, the team member, 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 and Limited Dental/Vision FSA | You 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, and Disability Plans | 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 — requires 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?

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Action Allowed</th>
</tr>
</thead>
</table>
| Medical, Dental, or Vision | You may drop your covered dependent child who is the subject of the order requiring another individual to provide the same type of coverage for that child or 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 and Limited Dental/Vision FSA | 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, and Disability Plans | Refer to the applicable chapter in this Benefits Book for information on allowed election changes. |

1. The child may only be dropped from the specific coverage type that another individual is required to provide under the order (for example, if the order requires another person to provide medical coverage for the child, the child can be dropped from your medical coverage at Wells Fargo but cannot be dropped from dental or vision coverage).

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

Dropping ineligible dependents during the year
If, at any time after you enroll, your covered dependent no longer meets the eligibility requirements (for example, loss of foster parent or legal guardianship appointment, divorce of a spouse, or any other event that results in a loss of eligibility), you must call Team Member Care (formerly known as the HR Service Center) 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 his or her coverage. For more information about dependent eligibility, see the “Eligible dependents” section starting on page 1-5.

Dependents who lose 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 notify Team Member Care (formerly known as the HR Service Center), he or she 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 notify Team Member Care (formerly known as the HR Service Center) that the dependent is ineligible, 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. 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. In this case, the actual change in coverage and corresponding cost for coverage is effective the first of the following month.

Dropping dependents during Annual Benefits Enrollment
During Annual Benefits Enrollment, you may drop any covered dependent from your coverage.

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

If you have dropped a spouse, domestic partner, or other covered dependent during Annual Benefits Enrollment, you may not add them back to your coverage during the year unless you experience a corresponding Qualified Event or special enrollment event; see the “Changing coverage” section starting on page 1-18.

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.
Removing a dependent who becomes a Wells Fargo team member or a covered dependent of another Wells Fargo team member

In the event that one of your covered dependents becomes a Wells Fargo team member and elects coverage as a team member, he or she is no longer an eligible dependent under the benefit plan options and must be removed from your coverage. You must call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, to remove this dependent from coverage. Note: This does not apply to Life Insurance coverage.

In the event that one of your covered dependents becomes a covered dependent under another Wells Fargo team member, he or she is no longer eligible to be covered under your benefit plan options and must be removed from your coverage. You must call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, to remove this dependent from coverage. Effective date

The dependent’s coverage will end as of the date his or her own team member coverage begins with Wells Fargo or the date his or her coverage is effective under the other Wells Fargo-sponsored benefit option if you call Team Member Care (formerly known as the HR Service Center) prior to your dependent’s coverage becoming effective. If you call Team Member Care after your dependent’s coverage effective date, the coverage will drop the last day of the month in which you call Team Member Care. The applicable change in premium or contribution will take effect on the next available pay period following the date you call Team Member Care.

Removing 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”), he or she is no longer an eligible dependent under the Wells Fargo & Company Health Plan (“Health Plan”) and must be removed from your team member medical, dental, and vision coverage. In the event that your dependent child becomes a covered dependent under the Retiree Plan, he or she is no longer an eligible dependent under the Health Plan and must be removed from your team member medical, dental, and vision coverage. You must call Team Member Care (formerly known as the HR Service Center) 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 his or her coverage begins under the Retiree Plan if you call Team Member Care (formerly known as the HR Service Center) prior to your dependent’s Retiree Plan coverage becoming effective. If you call Team Member 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 Team Member 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 Team Member Care.

Dropping your coverage

You may drop your medical, dental, vision, or legal services plan coverage during the Annual Benefits Enrollment Period. See the “Annual Benefits Enrollment” section starting on page 1-19 for more information.

You may not drop your medical, dental, vision, and legal services plan coverage or your participation in a flexible spending account during the plan year unless you have a Qualified Event and your election to drop your coverage is consistent with the Qualified Event. If you don’t have a Qualified Event during the plan year, you must wait until the next Annual Benefits Enrollment period to drop coverage. See the “Annual Benefits Enrollment” section starting on page 1-19 and the “Qualified Events” section starting on page 1-22 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, or life insurance coverage at any time by calling Team Member Care (formerly known as the HR Service Center) 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 call Team Member Care (formerly known as the HR Service Center), 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 you die
If you die while you are a covered team member at Wells Fargo and you also provide coverage for your dependents, your dependents may continue their coverage for a limited period of time under COBRA (see “Appendix E: Continuing Coverage Under COBRA” for more information). The first 12 months of COBRA coverage for medical, dental, and vision coverage will be paid by Wells Fargo in full. Thereafter, your surviving dependents must pay the full COBRA premium.

If you were a participant in the Full-Purpose Health Care Flexible Spending Account, the Limited Dental/Vision Flexible Spending Account, or the Day Care Flexible Spending Account, your dependents or the executor of your estate may continue to file claims for eligible expenses incurred while you were a participant until your account balances are used up, or until the final claim deadline, whichever occurs first. (For more information on the 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)” and “Chapter 6: Day Care Flexible Spending Account.”) Your dependents may be eligible to continue coverage under the Wells Fargo & Company Health Care Flexible Spending Account Plan by enrolling through COBRA and making after-tax contributions by check. Note: Wells Fargo does not make any contributions to a flexible spending account, even during the first 12 months of COBRA. (For more information on continuing coverage under COBRA, see “Appendix E: Continuing Coverage Under COBRA.”)

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

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.

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.
When coverage ends

Team member coverage under the medical, dental, and vision benefit options of the Health Plan, and the Full-Purpose Health Care Flexible Spending Account, or the Limited Dental/Vision Flexible Spending Account ends:

• On the date the applicable plan or benefit option is no longer offered*

• On the last day of the month for which timely full payment was last received for coverage if you have failed to make timely continued required contributions for coverage

• On the last day of the month in which one of the following events occurs or has been processed, whichever is later:
  – Your last day of employment takes place.
  – You no longer meet the benefits eligibility requirements (for eligibility requirements, see the “Who's eligible to enroll” section starting on page 1-4).

• The last day of the month in which one of the following events occurs or following the date Team Member Care (formerly known as the HR Service Center) is notified of the event, whichever is later:
  – You voluntarily make a permitted election to drop coverage 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.)
  – You die.

* For information on Wells Fargo’s ability to amend, modify, or terminate the plans, see the “Future of the plans” section in “Appendix B: Important Notifications and Disclosures.”

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

To determine when coverage ends under the 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 Long-Term Disability Plan, the Salary Continuation Pay Plan, or the Legal Services 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 in the following situations:

• For a spouse, when there is a legal separation or the marriage is dissolved.

• For a domestic partner, when the partnership terminates.

• For any dependent, when he or she no longer meets dependent eligibility requirements.

• The last day of the month in which you voluntarily make a permitted election to drop coverage of a covered dependent 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 notify Team Member Care (formerly known as the HR Service Center), 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.
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<thead>
<tr>
<th>Benefit plan name</th>
<th>Benefit option</th>
<th>SPD components</th>
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</table>
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• “Chapter 2: Medical Plans”  
• “Appendix A: Claims and Appeals”  
• “Appendix B: Important Notifications and Disclosures”  
• “Appendix D: Leaves of Absence and Your Benefits”  
• “Appendix E: Continuing Coverage Under COBRA” |
| Wells Fargo & Company Health Plan | HSA-Based Medical Plan – Gold (including HSA-Based Medical Plan – Gold 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: An Introduction to Your Benefits”  
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| Wells Fargo & Company Health Plan | HSA-Based Medical Plan – Silver (including HSA-Based Medical Plan – Silver 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: An Introduction to Your Benefits”  
• “Chapter 2: Medical Plans”  
• “Appendix A: Claims and Appeals”  
• “Appendix B: Important Notifications and Disclosures”  
• “Appendix D: Leaves of Absence and Your Benefits”  
• “Appendix E: Continuing Coverage Under COBRA” |
| Wells Fargo & Company Health Plan | Indemnity Medical Plan — Anthem BCBS  
Available only to team members living in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan) (self-insured) | • “Chapter 1: An Introduction to Your Benefits”  
• “Chapter 2: Medical Plans”  
• “Appendix A: Claims and Appeals”  
• “Appendix B: Important Notifications and Disclosures”  
• “Appendix D: Leaves of Absence and Your Benefits”  
• “Appendix E: Continuing Coverage Under COBRA” |
| Wells Fargo & Company Health Plan | HMO — Kaiser  
Available in certain locations (insured)  
Kaiser Evidence of Coverage SPD (sent directly by Kaiser)  
“Appendix B: Important Notifications and Disclosures”  
“Appendix D: Leaves of Absence and Your Benefits”  
“Appendix E: Continuing Coverage Under COBRA” | • “Chapter 1: An Introduction to Your Benefits”  
• “Appendix B: Important Notifications and Disclosures”  
• Kaiser Evidence of Coverage SPD (sent directly by Kaiser)  
• “Appendix D: Leaves of Absence and Your Benefits”  
• “Appendix E: Continuing Coverage Under COBRA” |

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<td>Available in Hawaii only (insured)</td>
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• Limited Dental/Vision Flexible Spending Account | • “Chapter 1: An Introduction to Your Benefits”  
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• Only the “Plan information,” “Participating employers,” and “Future of the plans” sections apply  
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| 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: An Introduction to Your Benefits”  
• “Chapter 7: Life Insurance Plan”  
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| Wells Fargo & Company Business Travel Accident Plan    | Business Travel Accident (BTA) Plan (insured)        | • “Chapter 1: An Introduction to Your Benefits”  
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| Wells Fargo & Company Accidental Death and Dismemberment Plan | Accidental Death and Dismemberment (AD&D) Plan (insured) | • “Chapter 1: An Introduction to Your Benefits”  
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3. Refer to the “Your rights under ERISA,” “Plan sponsor,” “Agent for service,” “Plan year,” “Participating employers,” and “Future of the plans” sections.
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Medical Plans

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<td>myuhc.com</td>
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<tr>
<th>Information about the medical plans administered by Anthem BCBS</th>
<th>1-866-418-7749</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>anthem.com</td>
</tr>
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<table>
<thead>
<tr>
<th>Information about the medical plans administered by HealthPartners</th>
<th>1-888-487-4442</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>952-883-6677 Twin Cities metro area</td>
</tr>
<tr>
<td></td>
<td>healthpartners.com/wf</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information about prescription drug coverage administered by CVS Caremark</th>
<th>1-800-772-2301</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>caremark.com</td>
</tr>
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<thead>
<tr>
<th>Information about earning health and wellness dollars as well as wellness-related activities</th>
<th>Optum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-877-543-4294</td>
</tr>
<tr>
<td></td>
<td>wellness.myoptumhealth.com</td>
</tr>
</tbody>
</table>

| Information about premiums | Check your enrollment materials, or go to Teamworks. |

<table>
<thead>
<tr>
<th>Information about providers in your area</th>
<th>mycastlight.com/wf</th>
</tr>
</thead>
<tbody>
<tr>
<td>You may also access the claims administrator’s website (see the applicable reference on this page).</td>
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<tr>
<th>Information about enrollment</th>
<th>Teamworks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Member Care (formerly known as the HR Service Center)</td>
<td>1-877-HRWELLS (1-877-479-3557), option 2</td>
</tr>
<tr>
<td>Team Member Care accepts relay service calls. TDD/TTY users may call 1-800-988-0161.</td>
<td></td>
</tr>
</tbody>
</table>
## Medical plans by location

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>Medical Claims Administrator</th>
<th>State or Territory</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRA-Based Medical Plan*</td>
<td>UnitedHealthcare</td>
<td>Alabama, Arizona, Arkansas, California – Northern, Colorado, District of Columbia, Florida, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Utah, Wisconsin, Wyoming</td>
</tr>
<tr>
<td>HSA-Based Medical Plan – Silver*</td>
<td></td>
<td>UnitedHealthcare</td>
</tr>
<tr>
<td>* Including Out of Area, where applicable</td>
<td></td>
<td>HealthPartners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Minnesota</td>
</tr>
<tr>
<td>Indemnity Medical Plan — Anthem BCBS¹</td>
<td>Anthem Blue Cross Blue Shield</td>
<td>Puerto Rico, Guam, and the Northern Mariana Islands (Saipan) Not available in the 50 United States or in the District of Columbia</td>
</tr>
<tr>
<td>CVS Caremark is the prescription drug administrator for all plans listed above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO — Kaiser²</td>
<td>Kaiser Permanente</td>
<td>California, Colorado, Oregon (Portland and Salem areas only), Washington (Vancouver, Longview, and Kelso areas only)</td>
</tr>
<tr>
<td>High-Deductible Health Plan (HDHP) — Kaiser²</td>
<td>Kaiser Permanente</td>
<td>California, Colorado, Oregon (Portland and Salem areas only), Washington (Vancouver, Longview, and Kelso areas only)</td>
</tr>
<tr>
<td>POS Kaiser Added Choice — Hawaii²</td>
<td>Kaiser Permanente</td>
<td>Hawaii</td>
</tr>
</tbody>
</table>

1. The Indemnity Medical Plan — Anthem BCBS is only offered in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan).

2. These plans are either an HMO or HDHP and are fully insured medical plans under the Wells Fargo & Company Health Plan. The benefits described in this chapter do not apply. The descriptions of plan benefits for the various HMO — Kaiser, HDHP — Kaiser, and POS Kaiser Added Choice — Hawaii coverage options are provided in separate documentation that will be sent to you by Kaiser if you enroll in the applicable plan. The information that comprises the complete SPD for the applicable Kaiser plan is noted in “Chapter 1: An Introduction to Your Benefits.”

Note: If your permanent home address on record is outside the United States or its territories (Puerto Rico, Guam, or Northern Mariana Islands (Saipan)), you are not eligible to be enrolled in a medical benefit option under the Health Plan. However, if you change your home address to an address outside the United States and you are on International Assignment, you may be eligible for medical coverage under the Wells Fargo & Company International Plan (see the “Additional requirements for the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance” section in “Chapter 1: An Introduction to Your Benefits”).
The information in this chapter — along with that in “Chapter 1: An Introduction to Your Benefits,” “Appendix A: Claims and Appeals,” “Appendix B: Important Notifications and Disclosures,” “Appendix D: Leaves of Absence and Your Benefits,” and “Appendix E: Continuing Coverage Under COBRA” — constitutes the Summary Plan Description (SPD) for your medical plan. The medical plan option in which you enroll is considered your “medical plan.”

The basics

General information
Wells Fargo sponsors various medical plan options as part of the Wells Fargo & Company Health Plan (the Health Plan). Refer to the “Medical plans by location” section on page 2-4 to determine the medical plan options available to you.

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

The following self-insured medical plan options are described in this chapter:

- Health Reimbursement Account (HRA)-Based Medical Plan*

- Health Savings Account (HSA)-Based Medical Plan – Gold*

- Health Savings Account (HSA)-Based Medical Plan – Silver*

* Including Out of Area. Unless otherwise indicated, references in this chapter to the HRA-Based Medical Plan, HSA-Based Medical Plan – Gold, and HSA-Based Medical Plan – Silver apply to the applicable Out of Area coverage.

Note: The health savings account that you open in conjunction with your enrollment in the HSA-Based Medical Plan – Gold, HSA-Based Medical Plan – Silver, or the HDHP — Kaiser medical plans is not part of the Health Plan or any other ERISA-covered benefit plan sponsored by Wells Fargo. See “Appendix C: Health Savings Accounts” for more information about the health savings account.

- Indemnity Medical Plan — Anthem BCBS
You must be enrolled in a medical plan on the date of service to receive applicable benefits under that medical plan.

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

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

As always, it is between you and your provider to determine the services and supplies you will receive. The provisions governing your medical plan control what, if any, benefits are available for the services you receive. The fact that a physician has performed or prescribed a procedure or treatment, or the fact that it may be the only treatment for a condition, sickness, or illness does not mean that it is a covered health service. Under each of the medical plans, the definition of a covered health service (see the “What the medical plans cover” section starting on page 2-49) relates only to what is covered by the medical plan and may differ from what your physician believes should be a covered health service.

Who’s eligible
Regular and part-time Wells Fargo team members are eligible to enroll in a medical plan. If you are enrolled as an eligible team member, 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 a team member and spouse or domestic partner, or a team member and a dependent child at the same time. Also, a dependent can only be covered under one team member. Detailed eligibility requirements are described in the “Who’s eligible to enroll” section in “Chapter 1: An Introduction to Your Benefits.”

If your permanent home address on record is outside the United States or its territories (Puerto Rico, Guam, or Northern Mariana Islands (Saipan)), you are not eligible to be enrolled in a medical benefit option under the Health Plan. However, if you change your home address to an address outside the United States and you are on International Assignment, you may be eligible for medical coverage under the Wells Fargo & Company International Plan (see the “Additional requirements for the Wells Fargo & Company International Plan, UnitedHealthcare Global — Expatriate Insurance” section in “Chapter 1: An Introduction to Your Benefits”).
How to enroll and when coverage begins

Refer to the “How to enroll” section in “Chapter 1: An Introduction to Your Benefits” for the time frame and process for enrollment. After you have enrolled, coverage will begin as described in the “When coverage begins” section in “Chapter 1: An Introduction to Your Benefits.”

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

- “How the HRA-Based Medical Plan works” section starting on page 2-11
- “How the HSA-Based Medical Plan – Gold and the HSA-Based Medical Plan – Silver work” section starting on page 2-23
- “How the Indemnity Medical Plan — Anthem BCBS works” section starting on page 2-30
- “Health and wellness activities” section starting on page 2-34

Changing or canceling coverage

You may make changes to your enrollment election during the Annual Benefits Enrollment period or if you experience certain Qualified Events or a Special Enrollment Right during the year. For more information on making enrollment election changes, refer to the “Changing coverage” section in “Chapter 1: An Introduction to Your Benefits.”

If you 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 HRA-Based Medical Plan works” section starting on page 2-11
- “How the HSA-Based Medical Plan – Gold and the HSA-Based Medical Plan – Silver work” section starting on page 2-23
- “How the Indemnity Medical Plan — Anthem BCBS works” section starting on page 2-30
- “Health and wellness activities” section starting on page 2-34

When coverage ends

Medical coverage for you or any enrolled dependents ends as described in the “When coverage ends” section in “Chapter 1: An Introduction to Your Benefits.”

Cost

You must make contributions to pay for the cost of medical coverage for yourself and any covered dependents. For more information, refer to the “Cost and funding” section in “Chapter 1: An Introduction to Your Benefits.”

Claims administrator

The HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, the HSA-Based Medical Plan – Silver, and the Indemnity Medical Plan – Anthem BCBS options are self-insured. However, third-party administrators, known as claims administrators, provide claims administrative services. The state or territory in which you reside determines which claims administrator provides these services for your medical claims. Refer to the “Medical plans by location” section on page 2-4.

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

Providers and provider networks

Under the medical plans, you have the choice to see any provider for most covered health services, and no referrals are required to see a specialist. However, it is recommended that you have a primary care physician (PCP) whom you see regularly and who can coordinate your care. Depending on your location, you may be able to receive services from in-network providers.

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

The claims administrators each have a national network. So, when you travel, use providers in another state, or if you have dependents living out of state, you may have in-network providers available to you throughout the U.S. Contact your claims administrator for information about the availability of in-network providers in a specific area.

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.
HRA-Based Medical Plan
If you are enrolled in the HRA-Based Medical Plan and live within the network service area for your state’s claims administrator, you may choose to use an in-network provider or an out-of-network provider. The in-network providers available to you depend on the networks that the applicable claims administrator has in your state. When you receive services from an in-network provider, you can take advantage of negotiated reimbursement rates. In addition, the plan will pay a greater percentage of the cost of covered health services received from in-network providers after you’ve met the annual deductible.

However, if you are enrolled in the HRA-Based Medical Plan, and your home ZIP code is outside the network service area for your state’s claims administrator, you will have HRA-Based Medical Plan Out of Area coverage (if your home ZIP code is within the network service area for your state’s claims administrator, you are not eligible for the HRA-Based Medical Plan Out of Area coverage). If you are eligible for Out of Area coverage, this indicates there are few, if any, network providers in your area. Under Out of Area coverage, the applicable cost-sharing is the same regardless of whether you receive services from an in-network or out-of-network provider. If you are able to receive services from an in-network physician or hospital, you can take advantage of network negotiated rates. It is important to note that there is no guarantee that you will have access to an in-network provider, and the level of benefits payable for covered health services remains the same whether your care is received from an in-network provider or not.

HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver
If you are enrolled in the HSA-Based Medical Plan – Gold or the HSA-Based Medical Plan – Silver and live within the network service area for your state’s claims administrator, you may choose to use an in-network provider or an out-of-network provider. The in-network providers available to you depend on the networks that the applicable claims administrator has in your state. When you receive services from an in-network provider, you can take advantage of network negotiated rates. In addition, the plan will pay a greater percentage of the cost of covered health services received from in-network providers after you’ve met the annual deductible.

However, if you are enrolled in the HSA-Based Medical Plan – Gold or the HSA-Based Medical Plan – Silver and your home ZIP code is outside the network service area for your state’s claims administrator, you will have either the HSA-Based Medical Plan – Gold Out of Area coverage or HSA-Based Medical Plan – Silver Out of Area coverage as applicable (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). Under Out of Area coverage, the applicable cost-sharing is the same regardless of whether you receive services from an in-network or out-of-network provider. If you are able to receive services from an in-network physician or hospital, you can take advantage of network negotiated rates. It is important to note that there is no guarantee that you will have access to an in-network provider, and the level of benefits payable for covered health services remains the same whether your care is received from an in-network provider or not.

Indemnity Medical Plan — Anthem BCBS
If you are enrolled in the Indemnity Medical Plan — Anthem BCBS, you are not required to use an in-network provider; the level of benefits available for covered health services is the same for services received from an in-network or an out-of-network provider. However, you can take advantage of network negotiated rates if you are able to receive services from an in-network provider.

Claims administrator networks
The provider networks associated with the medical claims administrators are noted below.

UnitedHealthcare provider networks:
To determine if UnitedHealthcare is your claims administrator, refer to the “Medical plans by location” section on page 2-4. Depending on your place of residence, the UnitedHealthcare Choice Plus Network and the Harvard Pilgrim network of doctors and hospitals (available only in Maine, Massachusetts, and New Hampshire) are the networks of providers associated with the HRA-Based Medical Plan, HSA-Based Medical Plan – Gold, and the HSA-Based Medical Plan – Silver administered by UnitedHealthcare. You may identify in-network providers on your UnitedHealthcare website at myuhc.com. You may also identify in-network providers using Castlight through Teamworks or at mycastlight.com/wf.

Anthem BCBS provider networks:
To determine if Anthem BCBS is your claims administrator, refer to the “Medical plans by location” section on page 2-4. Depending on place of residence, team members have access to the BlueCard PPO provider network, the Georgia Blue Open Access network, or the BlueCard Worldwide network. See the information below for more details.

• For the HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, and the HSA-Based Medical Plan – Silver:
  – The network used nationally is the BlueCard PPO network.
Georgia uses the Georgia Blue Open Access network for services in Georgia and the BlueCard PPO network when traveling outside Georgia.

- For the applicable Out of Area coverage, there are no in-network requirements.
- For the Indemnity Medical Plan — Anthem BCBS, in Puerto Rico, the network of providers is the BlueCard PPO network.
- For the Indemnity Medical Plan — Anthem BCBS, in Guam and the Northern Mariana Islands (Saipan), the network of providers is the BlueCard Worldwide network.

If you travel or have a covered dependent living outside of your home network area, contact Anthem BCBS for information about its national BlueCard PPO network.

You may identify in-network providers at anthem.com.
You may also identify in-network providers using Castlight through Teamworks or at mycastlight.com/wf.

HealthPartners provider networks:
To determine if HealthPartners is your claims administrator, refer to the “Medical plans by location” section on page 2-4. Network providers are the participating licensed medical professional providers and facilities that have entered into an agreement with HealthPartners to provide health care services to covered persons associated with the HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, and the HSA-Based Medical Plan – Silver administered by HealthPartners. To identify in-network providers in Minnesota, you may access healthpartners.com/wf. You may also identify in-network providers using Castlight through Teamworks, or at mycastlight.com/wf. If you are traveling in another state, or you have dependents who live outside of Minnesota, you can find in-network providers in the national open access network by visiting healthpartners.com/wf.

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 his or her license or certification
- A provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child, including any service the provider may perform on himself or herself
- A provider with the same legal residence as the patient

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 coverage level 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. Note: For the 2018 plan year, the in-network and out-of-network annual deductibles and annual out-of-pocket maximums do not accumulate jointly. Therefore, charges for services in-network do not count toward your out-of-network annual deductible and annual out-of-pocket expenses and vice versa.

The annual deductible will be adjusted for midyear coverage level election changes. For more information, see the applicable section:
- “How the HRA-Based Medical Plan works” section starting on page 2-11
- “How the HSA-Based Medical Plan – Gold and the HSA-Based Medical Plan – Silver work” section starting on page 2-23
- “How the Indemnity Medical Plan — Anthem BCBS works” section starting on page 2-30

The following do not count toward the annual deductible in the HRA-Based Medical Plan (including applicable Out of Area coverage):
- 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
- Charges for services that are not covered under the plan
- 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 in excess of the eligible expense, including amounts in excess of the allowed amount, balance billed by out-of-network providers
- Copays and coinsurance for prescription drugs
- The 20% coinsurance paid toward the office visit charge for a PCP office visit or an outpatient mental health or substance abuse provider office visit
The following do not count toward the annual deductible in either the HSA-Based Medical Plan – Gold or the HSA-Based Medical Plan – Silver (including applicable Out of Area coverage):

- 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
- Charges for services that are not covered under the plan
- Charges in excess of the eligible expense, including amounts in excess of the allowed amount, balance billed by out-of-network providers
- The reduction amount applied that resulted from the failure to follow the pre-service authorization procedures that would otherwise be payable for eligible covered health services
- Coinsurance for prescription drugs on the preventive therapy drug list

The following do not count toward the annual deductible in the Indemnity Medical Plan – Anthem BCBS:

- 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
- Charges for services that are not covered under the plan
- Charges in excess of the eligible expense, including amounts in excess of the allowed amount, balance billed by out-of-network providers
- The reduction amount applied that resulted from the failure to follow the pre-service authorization procedures that would otherwise be payable for eligible covered health services
- Copays and coinsurance for prescription drugs;
- prescription drug coverage has a separate out-of-pocket maximum for in-network prescription drugs (see the “In-network out-of-pocket maximums” section on page 2-129 for more information)

The annual deductible is referred to as “deductible” in the cost-sharing charts in the “Services covered under the medical plans” section starting on page 2-51.

**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 and the per plan year coinsurance. If you cover dependents, eligible expenses for all covered members accrue toward the applicable coverage level 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. Note: For the 2018 plan year, the in-network and out-of-network annual out-of-pocket maximums do not accumulate jointly. Therefore, charges for services in-network do not count toward your out-of-network annual out-of-pocket expenses and vice versa.

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

- “How the HRA-Based Medical Plan works” section starting on page 2-11
- “How the HSA-Based Medical Plan – Gold and the HSA-Based Medical Plan – Silver work” section starting on page 2-23
- “How the Indemnity Medical Plan – Anthem BCBS works” section starting on page 2-30

The following do not count toward the annual out-of-pocket maximum in the HRA-Based Medical Plan (including applicable Out of Area coverage):

- Charges for services that are not covered under the plan
- Charges in excess of the eligible expense, including amounts in excess of the allowed amount, balance billed by out-of-network providers
- The reduction amount applied that resulted from the failure to follow the pre-service authorization procedures that would otherwise be payable for eligible covered health services
- Charges for the difference in cost between a generic drug and a brand-name drug if a brand-name drug is selected when a generic is available
- Charges for services that are not covered under the plan
- Charges in excess of the eligible expense, including amounts in excess of the allowed amount, balance billed by out-of-network providers
- The reduction amount applied that resulted from the failure to follow the pre-service authorization procedures that would otherwise be payable for eligible covered health services
The following do not count toward the annual out-of-pocket maximum in the Indemnity Medical Plan — Anthem BCBS:

- Charges for services that are not covered under the plan
- Charges in excess of the eligible expense, including amounts in excess of the allowed amount, balance billed by out-of-network providers
- The reduction amount applied that resulted from the failure to follow the pre-service authorization procedures that would otherwise be payable for eligible covered health services
- Charges for the difference in cost between a generic drug and a brand-name drug if a brand-name drug is selected when a generic is available
- Copays and coinsurance for prescription drugs; prescription drug coverage has a separate individual and family out-of-pocket maximum for in-network prescription drugs (see the “In-network out-of-pocket maximums” section on page 2-129 for more information)

**Individual out-of-pocket maximum**

Under the individual out-of-pocket maximum, no one individual will be required to pay more than $7,350 in annual in-network, out-of-pocket expenses before the plan begins to pay 100% of covered eligible expenses. This individual maximum applies when the annual out-of-pocket maximum for the elected coverage level exceeds $7,350.

- For the HRA-Based Medical Plan when the applicable coverage level has an in-network annual out-of-pocket maximum higher than $7,350:
  - No one individual will pay more than $6,350 in eligible covered medical expenses for the in-network annual out-of-pocket maximum.
  - The prescription drug coverage is separate from the medical coverage; therefore, no one individual will pay more than $1,000 for prescription drugs for the in-network annual out-of-pocket maximum.

- For the HRA-Based Medical Plan Out of Area coverage when the applicable coverage level has an annual out-of-pocket maximum higher than $7,350:
  - No one individual will pay more than $6,350 in eligible covered medical expenses received from in-network and out-of-network providers combined for the annual out-of-pocket maximum.
  - The prescription drug coverage is separate from the medical coverage; therefore, no one individual will pay more than $1,000 for prescription drugs for the in-network annual out-of-pocket maximum.

- For the HSA-Based Medical Plan – Silver when the applicable coverage level has an in-network annual out-of-pocket maximum higher than $7,350:
  - No one individual will pay more than $7,350 in combined eligible covered medical and prescription drug expenses for the in-network annual out-of-pocket maximum.

- For the HSA-Based Medical Plan – Silver Out of Area coverage when the applicable coverage level has an annual out-of-pocket maximum higher than $7,350:
  - No one individual will pay more than $7,350 in eligible covered medical expenses (received from in-network and out-of-network providers combined) combined with in-network prescription drug eligible expenses for the annual out-of-pocket maximum.

**Coinsurance**

Coinsurance is the amount you pay toward eligible expenses for covered health services, generally after you have met the deductible, which is typically expressed as a percentage of the eligible expense. The amount of coinsurance you are required to pay may vary depending on whether you receive services from an in-network provider or an out-of-network provider and which medical plan you are enrolled in. You must meet the annual deductible before the coinsurance applies for all services unless specifically noted otherwise in this SPD. See the “What the medical plans cover” section starting on page 2-49 and the “Prescription drug benefit” section starting on page 2-127.

**Copay**

The copay is a fixed dollar amount you pay toward eligible expenses for certain covered health services such as prescription drugs. Copays generally must be paid to the provider at the time you receive the service. See the “Prescription drug benefit” section starting on page 2-127 for services subject to a copay. You do not need to meet the annual deductible before the copay applies.

**Plan year**

The plan year is the same as the calendar year, beginning on January 1 and ending the following December 31.
How the HRA-Based Medical Plan works

The HRA-Based Medical Plan has an associated health reimbursement account (HRA) to help you pay for eligible expenses for covered health services. For more information, see the “Health reimbursement account (HRA)” section starting on page 2-13, the “Covered health services definition” section starting on page 2-49, and the “Eligible expenses (allowed amount) definition” section starting on page 2-49.

Below is additional information to help you understand how the plan works depending on whether you receive services from in-network or out-of-network providers.

Services received from an in-network provider

The following applies if you reside within the claims administrator’s network area and receive services from an in-network provider or if you have Out of Area coverage and you receive services from an in-network provider:

- The available HRA dollars pay 100% of eligible expenses for covered health services until the available HRA dollars are exhausted for services subject to the annual deductible while you are in the deductible phase. However, the HRA dollars cannot be applied to prescription drug expenses. You pay 100% of eligible expenses after the available HRA dollars are exhausted until you reach the in-network (or if applicable, Out of Area coverage) annual deductible, with the following exceptions:
  - Office visit with a primary care physician — see the “Office visit — primary care physician (PCP)” section starting on page 2-89.
  - Office visit for mental health or substance abuse services — see the “Office visit — outpatient mental health and substance abuse” section starting on page 2-92.
  - Certain charges related to maternity care — see the “Maternity care” section starting on page 2-82.
  - Preventive care services — see the “Preventive care services (eligible preventive care services)” section starting on page 2-99, and the “Women’s preventive health care services” section starting on page 2-112.
  - Prescription drugs — see the “Prescription drug benefit” section starting on page 2-127 for information about what you will pay for prescription drugs.

- After you satisfy the in-network (or if applicable, Out of Area coverage) annual deductible, you will typically pay 20% coinsurance for your share of eligible expenses for most covered health services received from in-network providers. Refer to the “Services covered under the medical plans” section starting on page 2-51 and the corresponding cost-sharing tables starting on page 2-52 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 and coinsurance 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 2-127 for information about what you will pay for prescription drugs.

- Any available HRA dollars at the time the claim is processed will be applied to your coinsurance. However, the HRA dollars cannot be applied to prescription drug expenses or expenses not covered by the plan.

- For certain covered health services not subject to the annual deductible, the coinsurance does not count toward the annual deductible, but it does count toward the annual out-of-pocket maximum.

- 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 2-44.

- 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.

- After you satisfy the in-network (or if applicable, Out of Area coverage) annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services for which the in-network (or if applicable, Out of Area coverage) coinsurance would apply. However, you will continue to pay prescription drug expenses, up to the separate in-network individual or family prescription drug annual out-of-pocket maximum, even if the medical plan annual out-of-pocket maximum has been met.
For more information on in-network providers, see the “Providers and provider networks” section starting on page 2-6.

Services received from an out-of-network provider
The following applies if you reside within the claims administrator's network area and receive services from an out-of-network provider, or if you have Out of Area coverage and you receive services from an out-of-network provider:

- The available HRA dollars pay 100% of eligible expenses for covered health services until the available HRA dollars are exhausted for services subject to the annual deductible while you are in the deductible phase. (However, the HRA dollars cannot be used for prescription drug expenses.) You pay 100% of eligible expenses after the available HRA dollars are exhausted until you reach the out-of-network (or if applicable, Out of Area coverage) annual deductible, with the following exception:
  - Prescription drugs — see the “Prescription drug benefit” section starting on page 2-127 for information about what you will pay for prescription drugs.

For individuals with Out of Area coverage, the following exceptions also apply:

- Office visit with a primary care physician — see the “Office visit — primary care physician (PCP)” section starting on page 2-89.
- Office visit for mental health or substance abuse services — see the “Office visit — outpatient mental health and substance abuse” section starting on page 2-92.
- Certain charges related to maternity care — see the “Maternity care” section starting on page 2-82.
- Preventive care services — see the “Preventive care services (eligible preventive care services)” section starting on page 2-99, and the “Women's preventive health care services” section starting on page 2-112.

- After you satisfy the out-of-network annual deductible, you will typically pay 40% coinsurance for your share of eligible expenses for most covered health services received from out-of-network providers (or if applicable, after you have met the Out of Area coverage annual deductible, you will typically pay 20% coinsurance for your share of eligible expenses for most covered health services received from out-of-network providers). Refer to the “Services covered under the medical plans” section starting on page 2-51 and the corresponding cost-sharing tables starting on page 2-52 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 and coinsurance 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 2-127 for information about what you will pay for prescription drugs.

- Any available HRA dollars at the time the claim is processed will be applied to your coinsurance. However, HRA dollars cannot be applied to prescription drug expenses or expenses not covered by the plan.

- For individuals with Out of Area coverage only: Certain covered health services received from an out-of-network provider are not subject to the deductible; when that is the case, the applicable coinsurance does not count toward the annual deductible, but it does count toward the annual out-of-pocket maximum.

- 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 2-44) 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 2-119 for more information.) If the out-of-network provider files claims for you, you are responsible for ensuring the provider follows the plan’s claims filing requirements, including filing a claim within 12 months from date of service.

- You pay 100% for expenses above those considered eligible expenses by the plan. An out-of-network provider can bill you for all expenses the plan does not cover, including those above the eligible expense (or allowed amount), and you are responsible for payment to the out-of-network provider. The difference between the out-of-network provider’s billed charges and the eligible expense (allowed amount) is not applied toward the annual deductible, coinsurance amounts, or annual out-of-pocket maximum and is your responsibility. This applies to all out-of-network services described in this SPD chapter, including Out of Area coverage.

- You pay 100% for services and expenses not covered by the medical plan.

- After you satisfy the out-of-network (or if applicable, Out of Area coverage) annual out-of-pocket...
maximum, the medical plan pays 100% of eligible expenses for covered health services for which out-of-network (or if applicable, Out of Area coverage) coinsurance would apply. However, you will continue to pay prescription drug expenses up to the separate in-network individual or family prescription drug annual out-of-pocket maximum, even if the medical plan annual out-of-pocket maximum has been met.

Health reimbursement account (HRA)

If you enroll in the HRA-Based Medical Plan, Wells Fargo may allocate an amount to an HRA for you to use toward your eligible health care expenses each year. You and your covered spouse or domestic partner can have additional amounts allocated to your HRA by participating in certain health- and wellness-related activities. Refer to the “Health and wellness activities” section starting on page 2-34.

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, including health and wellness dollars, 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 allocated amounts in your HRA dollars to pay for eligible expenses. However, you cannot use HRA dollars allocated in the current year to pay for claims incurred in a previous year. Refer to the “Crossover claims” section on page 2-14. If you don’t use all of your HRA dollars and you remain enrolled in the HRA-Based Medical Plan 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 HRA-Based Medical Plan and filed within the claims filing period, subject to any limitations that may be imposed under the plan.

Note: If your claims administrator is UnitedHealthcare and your compensation category changes, there will be a 60-day delay in when the remaining funds will roll over to your Health Reimbursement Account for use in the following plan year.

Amounts allocated to your HRA are per coverage level (for example, you only, you + spouse, you + children, or you + spouse + children) and not per family member.

For more information about HRA dollars, refer to the “Health Reimbursement Account (HRA)-Based Medical Plan: HRA dollars, annual deductible, and annual out-of-pocket maximum” table on page 2-20.

For information on amounts allocated to an applicable HRA for a dependent who is no longer eligible for coverage and elects COBRA continuation coverage under the HRA-Based Medical Plan, see the “If a covered dependent becomes ineligible for coverage as a dependent during the year and elects COBRA coverage” section on page 2-22.

HRA dollars, including health and wellness dollars, are subject to all of the following restrictions:

- HRA dollars, including health and wellness dollars, may only be applied to covered health services as defined in this chapter.
- HRA dollars are not considered to be available to be applied to eligible expenses for covered health services until the HRA dollars have been allocated to your HRA.
- Health and wellness dollars may only be applied to covered health services after the health and wellness activities have been completed and the associated dollars have been allocated to your HRA. Claims processed before health and wellness dollars have been allocated to your HRA will not be reprocessed.
- You will forfeit all amounts allocated to your HRA, including health and wellness dollars, if your employment is terminated for any reason and you do not elect COBRA continuation coverage in the HRA-Based Medical Plan.
- You will forfeit all amounts allocated to your HRA, including health and wellness dollars, if you terminate employment and are eligible to elect retiree medical plan coverage but do not elect the HRA-Based Medical Plan under the Wells Fargo & Company Retiree Plan, or if you are eligible for Medicare; the HRA-Based Medical Plan under the Wells Fargo & Company Retiree Plan is not available to retirees or dependents who are eligible for Medicare.
- You will forfeit all amounts allocated to your HRA, including health and wellness dollars, if your HRA-Based Medical Plan 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.
You can keep track of the amounts allocated to your HRA by going online to your claims administrator’s website or by calling the number on the back of your medical plan ID card.

When you go to the doctor, show your medical plan ID card and any available amounts allocated to your HRA will automatically be applied to your eligible expenses for covered health services under the HRA-Based Medical Plan.

After the available HRA dollars are exhausted, the following rules apply:

- **Annual deductible.** After your available HRA dollars are exhausted, you pay the full cost of your expenses up to your annual deductible responsibility, unless otherwise noted in this SPD. Only the amount considered an eligible expense counts toward your annual deductible. You will still be responsible for prescription drug expenses up to the separate in-network individual or family prescription drug out-of-pocket maximum, even if you have met the annual deductible.

- **Coinsurance.** After you satisfy the annual deductible, you and the medical plan share costs, similar to traditional health coverage. You pay a percentage of eligible expenses for covered health services, up to a maximum annual out-of-pocket amount.

  Note: You are not required to satisfy the annual deductible before you pay 20% coinsurance for specified office visit charges.

- **Copays.** You pay applicable prescription drug copays regardless of any HRA dollars. You will continue to pay prescription drug copays and expenses up to the separate in-network individual or family prescription drug out-of-pocket maximum, even if you have met the medical plan annual out-of-pocket maximum.

- **Annual out-of-pocket maximum.** If you reach your annual out-of-pocket maximum, the HRA-Based Medical Plan pays 100% of eligible expenses (see the “Eligible expenses (allowed amount) definition” section starting on page 2-49 for more information). You will continue to pay prescription drug copays and expenses up to the separate in-network individual or family prescription drug out-of-pocket maximum, and all other charges not covered by this medical plan even if you reach your medical plan annual out-of-pocket maximum.

**Crossover claims**

You cannot use HRA dollars allocated during the current year for claims incurred in a previous year. Prior year claims will only apply to your prior year’s HRA balance. This means if you have a 2016 claim processed in January 2017 and your 2016 HRA balance is exhausted, you will be responsible for any patient responsibility from that claim. If there were still funds available from your 2016 HRA, the remaining 2016 HRA dollars can be applied to the eligible expenses portion of the 2016 claim.

As mentioned under the “Health reimbursement account (HRA)” section starting on page 2-13, any HRA balance remaining at the end of the year will roll forward to the next year. When claims are processed, your current year HRA dollars will be applied to claims incurred in the current year first. If the current year HRA balance is depleted and the prior year HRA still has an available balance, those prior year’s HRA dollars will be used to assist with the current year’s claims.

If your prior year’s funds have already been used to pay for current year claims and a claim from a previous year is subsequently processed, no HRA dollars will be available to be applied to the previous year’s claim. You will be responsible for any patient responsibility.

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

If you enroll midyear in the HRA-Based Medical Plan, Wells Fargo will allocate a prorated amount to your HRA. (The prorated amount is the annual amount divided by 12 and then multiplied by the number of months remaining in the year from the effective date of your coverage.) 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, under the HRA-Based Medical Plan. The amount of health and wellness dollars that you and your covered spouse or domestic partner can earn will also be subject to proration. For example, if you enroll midyear with coverage effective July 1 at the you only coverage level in compensation category 1, for the remainder of this plan year at this coverage level the following would apply:

- Your prorated HRA allocation would be $350.
- Your in-network annual deductible would be $2,000.
- Your in-network annual out-of-pocket maximum would be $4,000.
- You would only be 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 Wells Fargo & Company Health Plan do not count toward the annual deductible or the annual out-of-pocket maximum.

The above information applies to midyear enrollment in the HRA-Based Medical Plan by newly hired or rehired team members, team members who are newly benefits-
eligible due to an employment classification change, and team members who newly enroll because of a special enrollment right (see the “Special enrollment rights” section of “Chapter 1: An Introduction to Your Benefits”) or because of an allowable Qualified Event (see the “Qualified Events” section in “Chapter 1: An Introduction Your Benefits”). The above information also applies to a covered dependent of a team member who enrolls in the HRA-Based Medical Plan midyear as a COBRA-qualified beneficiary. The above information does not apply to certain rehired retirees (see the “Rehired retirees” section below).

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

If you had continuous COBRA medical coverage and you enroll in the HRA-Based Medical Plan as a rehired team member with no lapse in coverage, your HRA dollars and any health and wellness dollars earned under the Wells Fargo & Company Health Plan will be prorated as noted above. However, your annual deductible and annual out-of-pocket maximum are not prorated, regardless of the coverage level elected. For example, if, as a COBRA participant, you were enrolled in the you only coverage level in the HRA-Based Medical Plan under COBRA medical coverage and, as a rehire, you enroll midyear in the HRA-Based Medical Plan under the Wells Fargo & Company Health Plan with coverage effective July 1 at the you only coverage level in compensation category 1, for the remainder of this plan year at this coverage level, the following would apply:

- Your prorated HRA dollars would be $350.
- Your in-network annual deductible would be $2,000.
- Your in-network annual out-of-pocket maximum would be $4,000.
- You would only be eligible to earn up to $400 in health and wellness dollars.

Rehired retirees
This section applies to you if you are a retiree who is rehired by Wells Fargo & Company, you had retiree medical coverage under the Wells Fargo & Company Retiree Plan immediately preceding your date of rehire, and you elect the HRA-Based Medical Plan benefit option under Wells Fargo & Company Health Plan as a rehired team member.

Your HRA-Based Medical Plan coverage under the Health Plan is effective on your date of rehire. Your HRA dollars and any health and wellness dollars earned under the Wells Fargo & Company Health Plan will be prorated as noted above. However, your annual deductible and annual out-of-pocket maximum are not prorated, regardless of the coverage level elected. For example, if, as a rehired retiree, you enroll midyear in the HRA-Based Medical Plan under the Wells Fargo & Company Health Plan with coverage effective July 1 at the you only coverage level in compensation category 1, for the remainder of this plan year at this coverage level, the following would apply:

- Your prorated HRA allocation would be $350.
- Your in-network annual deductible would be $2,000.
- Your in-network annual out-of-pocket maximum would be $4,000.
- You would only be eligible to earn up to $400 in health and wellness dollars.

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

If the claims administrator changes as a result of your reenrollment in the HRA-Based Medical Plan upon your rehire, the following information applies. For claims incurred while you were covered under the HRA-Based Medical Plan benefit option under COBRA continuation coverage, the claims administrator will:

- Retain your HRA dollars, if any, for 60 days to apply to eligible medical claims incurred prior to the termination of your COBRA continuation coverage
- Initiate the transfer of any remaining HRA dollars on the 61st day to your new claims administrator for the HRA under the Wells Fargo & Company Health Plan
As a rehired retiree who had retiree medical coverage under the HRA-Based Medical Plan under the Wells Fargo & Company Retiree Plan immediately preceding your date of rehire and who elects the HRA-Based Medical Plan benefit option under the Wells Fargo & Company Health Plan as a rehired team member, the following will be applied to your HRA-Based Medical Plan coverage as a team member under the Wells Fargo & Company Health Plan:

- Any unused HRA dollars that are in your retiree HRA will continue to be used on eligible medical expenses or services.
- Amounts previously applied to your current year’s retiree annual deductible and annual out-of-pocket maximum will apply to your new HRA-Based Medical Plan annual deductible and annual out-of-pocket maximum for the same plan year (for eligible expenses incurred by you or eligible dependents that you covered under the HRA-Based Medical Plan benefit option of the Wells Fargo & Company Retiree Plan and who remain covered under the HRA-Based Medical Plan benefit option of the Wells Fargo & Company Health Plan).
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.

If the claims administrator changes as a result of your enrollment in the HRA-Based Medical Plan under the Wells Fargo & Company Health Plan upon your rehire, the following information applies. For claims incurred while you were covered under the HRA-Based Medical Plan benefit option under the Wells Fargo & Company Retiree Plan, the claims administrator will:

- Retain your HRA dollars, if any, for 60 days to apply to eligible medical claims incurred prior to the termination of coverage under the Wells Fargo & Company Retiree Plan per the terms of the Retiree Plan (reference to the Retiree Plan is for informational purposes only and is not part of the plan terms for the Health Plan).
- Initiate the transfer of any remaining HRA dollars on the 61st day to your new claims administrator for the HRA under the Wells Fargo & Company Health Plan.

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

**HRA dollars, 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: An Introduction to Your Benefits”) or other status change during the plan year resulting in an allowable change to your coverage level, the annual deductible and the annual out-of-pocket maximum will be adjusted to reflect the new coverage level 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 qualifying event will apply toward your adjusted annual deductible and adjusted annual out-of-pocket maximum for the remainder of the plan year.

When your coverage level is increased due to a Qualified Event, your HRA dollars are prorated and adjusted to your new coverage level for that plan year, minus any HRA dollars used in that plan year. (The prorated amount takes into consideration the annual amount divided by 12.) Any unused HRA dollars in your HRA that rolled over from previous plan years will remain in your HRA. If a person is added to your coverage who was previously enrolled in the HRA-Based Medical Plan and has any remaining HRA dollars in his or her individual HRA, those HRA dollars do not roll over to your HRA when he or she is added to your coverage. Additionally, health and wellness dollars are prorated for a spouse or domestic partner who is added midyear based on his or her effective date of coverage. For example, if your spouse is added to coverage on July 1, he or she would only be eligible to earn up to $400 for completing all health and wellness activities during the plan year.

When your coverage level decreases due to a Qualified Event, your HRA dollars are not adjusted to your new coverage level for that plan year. Your HRA dollars, minus any amounts used in the plan year, remain in the HRA. In addition, any unused HRA dollars that rolled over from previous plan years 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.
Chapter 2: Medical Plans

**COBRA enrollment**

If you are eligible for and elect COBRA continuation coverage for the HRA-Based Medical Plan during your initial COBRA enrollment period at the same level of coverage you had under the HRA-Based Medical Plan as a benefits-eligible team member, any HRA dollars, including health and wellness dollars remaining at the time your coverage as a team member terminates, will be available to help you pay for eligible covered expenses while your HRA-Based Medical Plan COBRA continuation coverage is in effect. You will not receive additional HRA dollars under COBRA continuation coverage for the current plan year. Eligible covered expenses previously applied to the current year’s annual deductible and annual out-of-pocket maximum for you, under your team member HRA-Based Medical Plan coverage, will apply to your HRA-Based Medical Plan COBRA continuation coverage for the same plan year.

If you extend coverage under your HRA-Based Medical Plan through COBRA and you do not elect the same level of coverage you had previously, your HRA, annual deductible, and annual out-of-pocket maximum will be adjusted but are not prorated as previously described for the remainder of the plan year.

If your dependent is no longer eligible for coverage under your HRA-Based Medical Plan coverage and elects COBRA medical coverage (separate from you) under the Wells Fargo & Company Health Plan during the year, see the “**If a covered dependent becomes ineligible for coverage as a dependent during the year and elects COBRA coverage**” section on page 2-22 for information on HRA allocation. 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 team member coverage will count toward the dependent’s new individual annual deductible and annual out-of-pocket maximum for the same plan year under COBRA medical coverage of the Wells Fargo & Company Health Plan. Also see the “**HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments**” section starting on page 2-14 for other information related to a midyear enrollment.

Lifetime benefits accruals for infertility and fertility services and treatment will transfer to the HRA-Based Medical Plan COBRA continuation coverage for any individual who has COBRA continuation coverage.

**Midyear changes in claims administrator if you move to a different state**

If you move to a different state while enrolled in the HRA-Based Medical Plan, you may have a different claims administrator. Please review the “**Medical plans by location**” section on page 2-4 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.
- Retain your HRA dollars, if any, for 60 days to apply to eligible medical claims incurred prior to the change in claims administrator. In addition:
  - After the 60 days, the remaining HRA dollars will not be available for any claims processed by the prior claims administrator.
  - For medical claims incurred prior to the effective date of your change in claims administrator and processed by your prior claims administrator after the 60-day period, you must pay for all charges incurred (including the portion of the claim considered an eligible expense) if you have not yet met your annual deductible; all other plan provisions apply.
- Initiate the transfer of any remaining HRA dollars on the 61st day to your new claims administrator. Note: Your HRA dollars will be unavailable for a period up to two business weeks during the transfer of your HRA dollars.

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

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

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

- Receive your remaining HRA balance (if any) from the prior claims administrator and apply it to any eligible medical claims incurred on and after the effective date of the change in claims administrator.
Note: If you move to a different state and experience a change in claims administrator and then terminate your employment or coverage before any remaining HRA dollars have been transferred to your new claims administrator, the HRA dollars will not transfer to your new claims administrator unless you elect COBRA continuation coverage. If you terminate employment and choose COBRA continuation coverage for the HRA-Based Medical Plan, any remaining HRA dollars from your coverage as a team member will be available under your COBRA continuation coverage.

**Midyear changes in medical plan benefit option**

If you move to a different state

If you have a change in residential address during the year, depending on where you move, your previous medical plan benefit option may not be available to you (such as an HMO — Kaiser, an HDHP — Kaiser medical plan, or the Indemnity Medical Plan — Anthem BCBS). If you elect to enroll in the HRA-Based Medical Plan midyear as a result of your change in residential address, please refer to the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14 for more information.

If you have a special enrollment right or Qualified Event

If you enroll in the HRA-Based Medical Plan midyear as a result of a special enrollment right or an allowable Qualified Event, please refer to the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14 for more information.

If you are enrolled in the HRA-Based Medical Plan 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 HRA-Based Medical Plan will end. Any HRA dollars, including health and wellness dollars, remaining at the time your HRA-Based Medical Plan coverage ends will be available for eligible expenses incurred prior to the termination of coverage if they are filed by the required claims filing deadline. After the claims filing deadline has passed, any remaining HRA dollars will be forfeited and will no longer be available.

**When you retire**

When you retire, your HRA-Based Medical Plan coverage under the Wells Fargo & Company Health Plan terminates at the end of the month in which you retire.

If you do not elect the HRA-Based Medical Plan coverage under the Wells Fargo & Company Retiree Plan, the claims administrator for your coverage as a team member will continue to process any eligible medical claims incurred before the termination of coverage and filed within 12 months of the date of service, including applying any remaining HRA dollars to such claims. Thereafter, any remaining HRA dollars will be forfeited.

Refer to “Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare” in the Retiree Benefits Book, available on Teamworks, for information about electing the HRA-Based Medical Plan coverage (or another coverage option, if applicable) under the Wells Fargo & Company Retiree Plan as a retiree. If you or a covered dependent are eligible for Medicare at the time you retire, refer to “Chapter 3: Medical Plans for Retirees Eligible for Medicare” in the Retiree Benefits Book, available on Teamworks, for information about your enrollment options.

If you elect the HRA-Based Medical Plan coverage under the Wells Fargo & Company Retiree Plan as a retiree, for claims incurred prior to the date your HRA-Based Medical Plan coverage terminates under the Wells Fargo & Company Health Plan, the claims administrator for your coverage under the Wells Fargo & Company Health Plan 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.
- Retain your HRA dollars, if any, for 60 days to apply to eligible medical claims incurred prior to the termination of coverage under the Wells Fargo & Company Health Plan. In addition:
  - After the 60 days, any remaining HRA dollars will not be available for claims processed by the claims administrator for the HRA-Based Medical Plan under the Wells Fargo & Company Health Plan.
  - For medical claims incurred prior to the termination of coverage, you must pay for all charges incurred (including the portion of the claim considered an eligible expense) if you have not yet met your annual deductible; all other plan provisions apply.
- Initiate the transfer of any remaining HRA dollars on the 61st day to your HRA under the Wells Fargo & Company Retiree Plan.
When you terminate employment, become ineligible for coverage, or drop coverage

Coverage ends as described in the “When coverage ends” section in “Chapter 1: An Introduction to Your Benefits.” You may be eligible to elect COBRA continuation coverage for the HRA-Based Medical Plan 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 HRA-Based Medical Plan, see the “COBRA enrollment” section on page 2-17.

If you do not elect COBRA continuation coverage, any HRA dollars, including health and wellness dollars, remaining at the time your HRA-Based Medical Plan coverage ends will be available for eligible expenses incurred prior to the termination of coverage and filed within the required claims filing time period. After the claims filing deadline has passed, any remaining HRA dollars will be forfeited.

When your COBRA continuation coverage ends, any HRA dollars, including health and wellness dollars, remaining at the time your HRA-Based Medical Plan coverage ends will be available for eligible expenses incurred prior to the termination of coverage and filed within the required claims filing time period. After the claims filing deadline has passed, any remaining HRA dollars will be forfeited.

If you elect another medical benefit option under the Wells Fargo & Company Health Plan at any time or otherwise elect to drop your HRA-Based Medical Plan coverage, your coverage under the HRA-Based Medical Plan will end. Any HRA dollars, including health and wellness dollars, remaining at the time your HRA-Based Medical Plan coverage ends will be available for eligible expenses incurred prior to the termination of coverage and filed within the required claims filing time period. After the claims filing deadline has passed, any remaining HRA dollars will be forfeited and will no longer be available.
Health Reimbursement Account (HRA)-Based Medical Plan: HRA dollars, annual deductible, and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the HRA-Based Medical Plan and are subject to the procedures, exclusions, and limitations in this chapter. Refer to the “Prescription drug benefit” section starting on page 2-127 for information about how prescription drugs are covered, including a separate and distinct in-network prescription drug out-of-pocket maximum.

### HRA allocation

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Annual allocation of HRA dollars based on HRA-eligible compensation category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Category 1 less than $60,000</td>
</tr>
<tr>
<td>You</td>
<td>$700</td>
</tr>
<tr>
<td>You + spouse¹</td>
<td>$700</td>
</tr>
<tr>
<td>You + children</td>
<td>$1,200</td>
</tr>
<tr>
<td>You + spouse¹ + children</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

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

### Annual deductible

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Your annual deductible responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network providers</td>
</tr>
<tr>
<td>You</td>
<td>$2,000</td>
</tr>
<tr>
<td>You + spouse¹</td>
<td>$3,200</td>
</tr>
<tr>
<td>You + children</td>
<td>$2,700</td>
</tr>
<tr>
<td>You + spouse¹ + children</td>
<td>$3,800</td>
</tr>
</tbody>
</table>

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

### Annual out-of-pocket maximum

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Your annual out-of-pocket maximum responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network providers</td>
</tr>
<tr>
<td>You</td>
<td>$4,000</td>
</tr>
<tr>
<td>You + spouse¹</td>
<td>$6,400¹</td>
</tr>
<tr>
<td>You + children</td>
<td>$5,200</td>
</tr>
<tr>
<td>You + spouse¹ + children</td>
<td>$7,600³</td>
</tr>
</tbody>
</table>

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

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

3. No one individual will need to pay more than $6,350 in eligible medical expenses for the annual out-of-pocket maximum. You are required to meet a separate prescription drug in-network annual out-of-pocket maximum. See the prescription drug “In-network out-of-pocket maximums” section on page 2-129 for more information.

### Health and wellness

<table>
<thead>
<tr>
<th>You</th>
<th>Health and wellness dollars you may earn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your covered spouse¹</td>
<td>Up to $800</td>
</tr>
</tbody>
</table>

1. For the purposes of this chapter, the term “spouse” includes your domestic partner, unless otherwise noted.
HRA-eligible compensation category
If you enroll in the HRA-Based Medical Plan, the Wells Fargo & Company Health Plan may allocate dollars to your HRA based on the coverage level you elect and your HRA-eligible compensation category. The allocation amounts are illustrated in the “Health Reimbursement Account (HRA)-Based Medical Plan: HRA dollars, annual deductible, and annual out-of-pocket maximum” table on page 2-20.

Your HRA-eligible compensation category is determined by your HRA-eligible compensation, an amount which is calculated based on eligible compensation principles similar to the determination of covered pay under the Wells Fargo & Company Long-Term Disability Plan (the LTD Plan).

For Annual Benefits Enrollment elections
Your HRA-eligible compensation for the next plan year is determined based on data on October 1 of the current plan year and the prior 12-month period. The HRA-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 below. The corresponding HR Information Systems (HRIS) job class assignment for each pay category is also listed:

- **Pay category — salaried team members, job class 2.** Your annualized base salary¹ and any certified eligible bonuses and commissions paid to you by Wells Fargo in the prior 12 months.

- **Pay category — Variable Incentive Compensation (VIC), job class 5, and Mortgage Consultant Participant, job class 1.** You will be placed in an HRA-eligible compensation category by annualizing your earnings based on certified eligible bonuses and commissions paid to you by Wells Fargo in the last 12 months. Note: The HRA amount is prorated for midyear elections. See the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14.

- **Pay category — hourly paid team members, job class 2.** Your annualized base salary¹ determined by taking your standard hours² multiplied by your hourly wage, plus any certified eligible bonuses and incentives paid to you by Wells Fargo as of your date of hire. Note: The HRA amount is prorated for midyear elections. See the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14.

For newly hired benefits-eligible team members (including rehired retirees and rehired team members)

- **Pay category — salaried team members, job class 2.** Your annualized base salary¹ and any certified, eligible bonuses and commissions paid to you by Wells Fargo as of your date of hire. Note: The HRA amount is prorated for midyear elections. See the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14.

- **Pay category — Variable Incentive Compensation (VIC), job class 5, and Mortgage Consultant Participant, job class 1.** For newly hired benefits-eligible team members, you will be placed in an HRA-eligible compensation category by annualizing your earnings as of your hire date. For rehires, you will be placed in an HRA-eligible compensation category by annualizing your earnings as of your hire date based on certified eligible bonuses and commissions paid to you by Wells Fargo in the last 12 months. Note: The HRA amount is prorated for midyear elections. See the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14.

- **Pay category — hourly paid team members, job class 2.** Your annualized base salary¹, determined by taking your standard hours² multiplied by your hourly wage, plus any bonuses and incentives paid to you by Wells Fargo as of your date of hire. Note: The HRA amount is prorated for midyear elections. See the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14.

¹ Annualized base salary includes amounts designated as before-tax contributions you make to Wells Fargo & Company-sponsored benefit plans. 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, auto allowance, or commute subsidies).

² Your standard hours are the hours that you’re expected to work each week, as maintained in the HR Information System (HRIS) 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.
If you become newly eligible for benefits during the plan year

Your HRA-eligible compensation is determined based on data on October 1 of the previous plan year for employment status changes that occur January 1–September 30, and are based on data on October 1 of the current plan year for employment status changes that occur October 1–December 31. The HRA-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 below. The corresponding HR Information Systems (HRIS) job class assignment for each pay category is also listed.

- **Pay category — salaried team members, job class 2.**
  Your annualized base salary¹ and any certified eligible bonuses and commissions paid to you by Wells Fargo in the prior 12 months. Note: The HRA amount is prorated for midyear elections. See the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14.

- **Pay category — Variable Incentive Compensation (VIC), job class 5, and Mortgage Consultant Participant, job class 1.**
  You will be placed in an HRA-eligible compensation category by annualizing your earnings based on certified eligible bonuses and commissions paid to you by Wells Fargo in the last 12 months. Note: The HRA amount is prorated for midyear elections. See the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14.

- **Pay category — hourly paid team members, job class 2.**
  Your annualized base salary¹, determined by taking your standard hours,² multiplied by your hourly wage, plus any eligible bonuses and incentives paid to you by Wells Fargo in the prior 12 months. Note: The HRA amount is prorated for midyear elections. See the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14.

   ¹ Annualized base salary includes amounts designated as before-tax contributions you make to Wells Fargo & Company-sponsored benefit plans. 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, auto allowance, or commute subsidies).

   ² Your standard hours are the hours that you’re expected to work each week, as maintained in the HR Information System (HRIS) 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.

If your coverage as an active team member terminates and you enroll in the same level of coverage as a COBRA participant

Your HRA-eligible compensation category remains the same as the HRA-eligible compensation category you were in on the day immediately prior to COBRA commencing. You will continue in this same category through the current and all future plan years while covered under COBRA. See the “COBRA enrollment” section on page 2-17 for more information about moving from active to COBRA coverage.

If a covered dependent becomes ineligible for coverage as a dependent during the year and elects COBRA coverage

The dependent will be placed in an HRA-eligible compensation category as determined by the team member’s category at the time of the dependent’s loss of eligibility. Note: The HRA amount is prorated for midyear elections. See the “HRA dollars, annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section starting on page 2-14 and the “COBRA enrollment” section on page 2-17 for more information about moving from active to COBRA coverage.

The Plan Administrator of the Wells Fargo & Company Health Plan, or its designee, has the ability to determine HRA-eligible compensation categories in accordance with its operating rules and procedures as reflected in the formal Plan document.
How the HSA-Based Medical Plan – Gold and the HSA-Based Medical Plan – Silver work

The HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver are high-deductible health plans that are compatible with a health savings account (HSA) and are available nationwide, except in the state of Hawaii. This section is for information on the HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver. (For information on the HDHP — Kaiser medical plan options, refer to the Kaiser Evidence of Coverage or the Summary Plan Description received directly from Kaiser Permanente.)

The HSA that you set up separately is not part of the Health Plan or any other ERISA-covered benefit plan sponsored by Wells Fargo. For more information about health savings accounts, see “Appendix C: Health Savings Accounts.”

You and your covered spouse or domestic partner may earn additional dollars to be deposited in your health savings account by participating in certain health- and wellness-related activities. For more information on earning additional dollars by participating in health and wellness activities, see the “Health and wellness activities” section starting on page 2-34.

The medical plan covers eligible expenses for covered health services. (See the “Covered health services definition” section starting on page 2-49 and the “Eligible expenses (allowed amount) definition” section starting on page 2-49 for more information.) Below is additional information to help you understand how the plan works depending on whether you receive services from in-network or out-of-network providers.

Services received from an in-network provider

The following applies if you reside within the claims administrator’s network area and receive services from an in-network provider or if you have Out of Area coverage and you receive services from an in-network provider:

• You pay 100% of eligible expenses for covered health services until you satisfy the in-network (or if applicable, Out of Area coverage) annual deductible, with the following exceptions:

  – Preventive care services — see the “Preventive care services (eligible preventive care services)” section starting on page 2-99 and the “Women’s preventive health care services” section starting on page 2-112.

  – Some prescription drugs — see the “Prescription drug benefit” section starting on page 2-127 for information about what you will pay for prescription drugs.

• After you satisfy the in-network (or if applicable, Out of Area coverage) annual deductible, you typically pay 20% coinsurance for your share of eligible expenses for most covered health services.

  – Refer to the “Services covered under the medical plans” section starting on page 2-51 and the corresponding cost-sharing tables starting on page 2-52 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.

  – Refer to the “Prescription drug benefit” section starting on page 2-127 for information about what you will pay for prescription drugs.

• 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.

• After you satisfy the in-network (or if applicable, the Out of Area coverage) annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services (including eligible prescription drug expenses) for which the in-network (or if applicable, the Out of Area coverage) coinsurance would apply.

For more information on in-network providers, see the “Providers and provider networks” section starting on page 2-6.

Services received from an out-of-network provider

The following applies if you reside within the claims administrator’s network area and receive services from an out-of-network provider or if you have Out of Area coverage and receive services from an out-of-network provider:

• You pay 100% of eligible expenses for covered health services until you satisfy the out-of-network (or if applicable, Out of Area coverage) annual deductible.

  – Some prescription drugs are covered without having to satisfy the annual deductible.

  – See the “Prescription drug benefit” section starting on page 2-127 for information about what you will pay for prescription drugs.
• After you satisfy the out-of-network annual deductible, you will typically pay 40% coinsurance for your share of eligible expenses for most covered health services received from out-of-network providers (or if applicable, after you have met the Out of Area coverage annual deductible, you will typically pay 20% coinsurance for your share of eligible expenses for most covered health services received from out-of-network providers).

– Refer to the “Services covered under the medical plans” section starting on page 2-51 and the corresponding cost-sharing tables starting on page 2-52 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.

– Refer to the “Prescription drug benefit” section starting on page 2-127 for information about what you will pay for prescription drugs.

• You pay 100% of the cost of nonpreventive prescription drugs until you satisfy the out-of-network annual deductible.

• You pay 20% of the cost of eligible preventive prescription drugs without having to satisfy the annual out-of-network deductible.

• 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 2-44) 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 2-119).

• You pay 100% of expenses above the considered eligible expenses. An out-of-network provider can bill you for all expenses the plan does not cover, including those above the eligible expense (or allowed amount) and you are responsible for payment to the out-of-network provider. The difference between the out-of-network provider’s charges and the eligible expense (allowed amount) under the medical plan is not applied toward the annual deductible, coinsurance amounts, or annual out-of-pocket maximum and is your responsibility. This applies to all out-of-network services described in this chapter, including Out of Area coverage.

• You pay 100% for services and expenses not covered by the medical plan.

– After you satisfy the out-of-network (or if applicable, Out of Area coverage) annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services for which out-of-network (or if applicable, Out of Area coverage) coinsurance would apply.

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

If you enroll midyear in either of the HSA-Based Medical Plans, you are required to meet the full year annual deductible and annual out-of-pocket maximum regardless of your effective date of coverage during the year. However, the amount of health and wellness dollars that you and your covered spouse or domestic partner can earn will be subject to proration. The prorated amount for health and wellness dollars is the annual amount divided by 12 and then multiplied by the number of months remaining in the year from the effective date of your coverage. For example, if you enroll midyear in the HSA-Based Medical Plan – Silver, with coverage effective July 1 at the you only coverage level, for the remainder of this plan year at this coverage level the following would apply:

• Your in-network annual deductible would be $3,000.

• Your in-network annual out-of-pocket maximum would be $5,000.

• You would only be 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 Wells Fargo & Company Health Plan do not count toward the annual deductible or annual out-of-pocket maximum.

The above information applies to midyear enrollment in either of the HSA-Based Medical Plans by newly hired or rehired team members, team members who are newly benefits-eligible due to an employment classification change, and team members who newly enroll because of a special enrollment right (see the “Special enrollment rights” section in “Chapter 1: An Introduction to Your Benefits”) or because of an allowable Qualified Event (see the “Qualified Events” section in “Chapter 1: An Introduction Your Benefits”).

The above information also applies to a covered dependent of a team member who enrolls in either of the HSA-Based Medical Plans midyear as a COBRA-qualified beneficiary. The above information does not apply to certain rehired retirees (see the “Rehired retirees” section starting on page 2-25).
Rehired COBRA participants
This section applies to you if you are a team member who is rehired by Wells Fargo & Company and you had COBRA medical coverage under the Wells Fargo & Company Health Plan immediately preceding your rehire date.

If you had continuous COBRA medical coverage and you enroll in the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver as a rehired team member with no lapse in coverage, any health and wellness dollars earned under the Wells Fargo & Company Health Plan will be prorated as noted above. However, your annual deductible and annual out-of-pocket maximum are not prorated, regardless of the coverage level elected.

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

- Your in-network annual deductible would be $3,000.
- Your in-network annual out-of-pocket maximum would be $5,000.
- You would only be eligible to earn up to $400 in health and wellness dollars.

As a rehired team member who had continuous COBRA medical coverage and enrolled in either of the HSA-Based Medical Plans benefit options during the rehire enrollment period, the following will be applied to your HSA-Based Medical Plan’s coverage as a team member under the Wells Fargo & Company Health Plan:

- Amounts previously applied to your current year’s COBRA annual deductible and annual out-of-pocket maximum will apply to your new HSA-Based Medical Plan 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 Wells Fargo & Company Health Plan and who remain enrolled under the HSA-Based Medical Plan benefit option of the Wells Fargo & Company Health Plan).
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.

Rehired retirees
This section applies to you if you are a retiree who is rehired by Wells Fargo & Company, you had retiree medical coverage under the Wells Fargo & Company Retiree Plan immediately preceding your date of rehire, and you elect the HSA-Based Medical Plan – Gold or the HSA-Based Medical – Silver under the Wells Fargo & Company Health Plan as a rehired team member.

Your HSA-Based Medical Plan coverage under the Health Plan is effective on your date of rehire. Any health and wellness dollars earned under the Wells Fargo & Company Health Plan will be prorated as noted above. However, your annual deductible and annual out-of-pocket maximum are not prorated, regardless of the coverage level elected. For example, if, as a rehired retiree, you enroll midyear in the HSA-Based Medical Plan – Silver under the Wells Fargo & Company Health Plan with coverage effective July 1 at the you only coverage level, for the remainder of this plan year at this coverage level the following would apply:

- Your in-network annual deductible would be $3,000.
- Your in-network annual out-of-pocket maximum would be $5,000.
- You would only be eligible to earn up to $400 in health and wellness dollars.

As a rehired retiree who had retiree medical coverage under the HSA-Based Medical Plan benefit option under the Wells Fargo & Company Retiree Plan immediately preceding your date of rehire and who elects the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver benefit option under the Wells Fargo & Company Health Plan as a rehired team member, the following will be applied to your HSA-Based Medical Plan coverage as a team member under the Wells Fargo & Company Health Plan:

- Amounts previously applied to your current year’s retiree annual deductible and annual out-of-pocket maximum will apply to your new HSA-Based Medical Plan annual deductible and annual out-of-pocket maximum for the same plan year (for eligible expenses incurred by you or eligible dependents that you covered under the HSA-Based Medical Plan benefit option of the Wells Fargo & Company Retiree Plan and who remain covered under the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver benefit option of the Wells Fargo & Company Health Plan).
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.
If the claims administrator changes as a result of your enrollment in the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver under the Wells Fargo & Company Health Plan upon your rehire, the claims administrator for your coverage under the Wells Fargo & Company Health Plan will only process any eligible medical claims incurred after the effective date of the change and filed within 12 months of the date of service.

If your retiree medical coverage under the Wells Fargo & Company Retiree Plan was a benefit option other than the HSA-Based Medical Plan, none of your previous expenses under the Wells Fargo & Company Retiree Plan will be credited toward the annual deductible or annual out-of-pocket maximum for the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver under the Wells Fargo & Company Health Plan.

**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: An Introduction to Your Benefits”) or other status change resulting in an allowable change to your coverage level, the annual deductible and the annual out-of-pocket maximum will be adjusted to reflect the new coverage level 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.

When your coverage level is increased due to a Qualified Event, your unearned health and wellness dollars are also adjusted to your new coverage level 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 his or her effective date of coverage. For example, if your spouse is added to coverage on July 1, he or she would only be eligible to earn up to $400 for completing all health and wellness activities during the plan year.

**COBRA enrollment**

If you are eligible for and elect COBRA continuation coverage for the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver during your initial COBRA enrollment period at the same level of coverage you had under the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver as a benefits-eligible team member, eligible covered expenses previously applied to the current year’s annual deductible and annual out-of-pocket maximum for you, under your team member HSA-Based Medical Plan’s coverage, will apply to either HSA-Based Medical Plan’s COBRA continuation coverage for the current plan year.

If you extend coverage under the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver through COBRA and you do not elect the same level of coverage you had previously, your annual deductible and annual out-of-pocket maximum may be adjusted as previously described for the remainder of the plan year.

If your dependent is no longer eligible for coverage under your HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver and elects COBRA medical coverage (separate from you) under the Wells Fargo & Company Health Plan 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 team member 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 Wells Fargo & Company Health Plan. Also see the “Annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section on page 2-24 for other information related to a midyear enrollment.

Lifetime benefits accruals for infertility and fertility services and treatment will transfer to either HSA-Based Medical Plan’s COBRA continuation coverage for any individual who has COBRA continuation coverage.

**Midyear changes in claims administrator if you move to a different state**

If you move to a different state while enrolled in either the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver, you may have a different claims administrator. Please review the “Medical plans by location” section on page 2-4 to determine the claims administrator for your state. Your change in claims administrator will be effective on the first day of the month following your move.

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

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

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

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

Midyear changes in medical plan benefit option

If you move to a different state

If you have a change in residential address during the year, depending on where you move, your previous medical plan benefit option may not be available to you (such as an HMO — Kaiser or HDHP — Kaiser medical plan, or the Indemnity Medical Plan — Anthem BCBS). If you elect to enroll in the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver midyear as a result of your change in residential address, please refer to the “Annual deductible, annual out-of-pocket maximum, and health and wellness dollars for midyear enrollments” section on page 2-24 for more information.

If you have a special enrollment right or a Qualified Event

If you enroll in one of the HSA-Based Medical Plans 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” section on page 2-24 for more information.

If you are enrolled in either the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver and, as a result of a special enrollment right or an eligible Qualified Event, elect coverage under another medical benefit option such as the HRA-Based Medical Plan or one of the Kaiser medical plans, your coverage under either the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver will end. The claims administrator will continue to process any eligible medical claims incurred before the termination of coverage and filed within the required claims filing time period.

When you retire

When you retire, your HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver coverage under the Wells Fargo & Company Health Plan terminates at the end of the month in which you retire.

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

Refer to “Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare” in the Retiree Benefits Book, available on Teamworks, for information about electing the HSA-Based Medical Plan coverage (or another coverage option, if applicable) under the Wells Fargo & Company Retiree Plan as a retiree. If you or a covered dependent are eligible for Medicare at the time you retire, refer to “Chapter 3: Medical Plans for Retirees Eligible for Medicare” in the Retiree Benefits Book, available on Teamworks, for information about your enrollment options.

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

Coverage ends as described in the “When coverage ends” section in “Chapter 1: An Introduction to Your Benefits.” You may be eligible to elect COBRA continuation coverage for the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver 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-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver, see the “COBRA enrollment” section on page 2-26.

If you do not elect COBRA continuation coverage for the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver, the claims administrator will continue to process any eligible medical claims incurred before the termination of coverage and filed within 12 months of the date of service.

If you elect another medical benefit option at any time or otherwise elect to drop coverage under one of the HSA-Based Medical Plans, your coverage under the HSA-Based 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 Savings Account (HSA)-Based Medical Plan – Gold: annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the HSA-Based Medical Plan – Gold and are subject to the procedures, exclusions, and limitations in this chapter. Refer to the “Prescription drug benefit” section starting on page 2-127 for information about how prescription drugs are covered.

### Annual deductible

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Your annual deductible responsibility</th>
<th>In-network providers</th>
<th>Out-of-network providers</th>
<th>Out of Area coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>Includes eligible prescription drugs</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>You + spouse¹</td>
<td></td>
<td>$3,200</td>
<td>$6,400</td>
<td>$3,200</td>
</tr>
<tr>
<td>You + children</td>
<td></td>
<td>$2,700</td>
<td>$5,400</td>
<td>$2,700</td>
</tr>
<tr>
<td>You + spouse¹ + children</td>
<td></td>
<td>$3,800</td>
<td>$7,600</td>
<td>$3,800</td>
</tr>
</tbody>
</table>

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

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

### Annual out-of-pocket maximum

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Your annual out-of-pocket maximum responsibility</th>
<th>In-network providers</th>
<th>Out-of-network providers</th>
<th>Out of Area coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>Includes deductible and eligible prescription drugs</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>You + spouse¹</td>
<td></td>
<td>$4,800</td>
<td>$9,600</td>
<td>$4,800</td>
</tr>
<tr>
<td>You + children</td>
<td></td>
<td>$3,900</td>
<td>$7,800</td>
<td>$3,900</td>
</tr>
<tr>
<td>You + spouse¹ + children</td>
<td></td>
<td>$5,700</td>
<td>$11,400</td>
<td>$5,700</td>
</tr>
</tbody>
</table>

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

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

### Health and wellness

<table>
<thead>
<tr>
<th></th>
<th>Your available health and wellness dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>Up to $800</td>
</tr>
<tr>
<td>Your covered spouse¹</td>
<td>Up to $800</td>
</tr>
</tbody>
</table>

1. For the purposes of this chapter, the term “spouse” includes your domestic partner, unless otherwise noted.
**Health Savings Account (HSA)-Based Medical Plan – Silver: annual deductible and annual out-of-pocket maximum**

These amounts apply to individuals enrolled in the HSA-Based Medical Plan – Silver and are subject to the procedures, exclusions, and limitations in this chapter. Refer to the “Prescription drug benefit” section starting on page 2-127 for information about how prescription drugs are covered.

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Your annual deductible responsibility</th>
<th>Includes eligible prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network providers</td>
<td>Out-of-network providers</td>
</tr>
<tr>
<td>You</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>You + spouse&lt;sup&gt;1&lt;/sup&gt;</td>
<td>$4,800</td>
<td>$9,600</td>
</tr>
<tr>
<td>You + children</td>
<td>$3,900</td>
<td>$7,800</td>
</tr>
<tr>
<td>You + spouse&lt;sup&gt;1&lt;/sup&gt; + children</td>
<td>$5,700</td>
<td>$11,400</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Your annual out-of-pocket maximum responsibility</th>
<th>Includes deductible and eligible prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network providers</td>
<td>Out-of-network providers</td>
</tr>
<tr>
<td>You</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>You + spouse&lt;sup&gt;1&lt;/sup&gt;</td>
<td>$8,000</td>
<td>$16,000</td>
</tr>
<tr>
<td>You + children</td>
<td>$6,500</td>
<td>$13,000</td>
</tr>
<tr>
<td>You + spouse&lt;sup&gt;1&lt;/sup&gt; + children</td>
<td>$9,500&lt;sup&gt;1&lt;/sup&gt;</td>
<td>$19,000</td>
</tr>
</tbody>
</table>

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

3. No one individual will need to pay more than $7,350 in eligible medical and prescription drug expenses for the annual out-of-pocket maximum.

### Health and wellness

<table>
<thead>
<tr>
<th></th>
<th>Your available health and wellness dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>Up to $800</td>
</tr>
<tr>
<td>Your covered spouse&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Up to $800</td>
</tr>
</tbody>
</table>

1. For the purposes of this chapter, the term “spouse” includes your domestic partner, unless otherwise noted.
How the Indemnity Medical Plan — Anthem BCBS works

This medical plan is only available to eligible employees who live in:

• Puerto Rico
• Guam
• Northern Mariana Islands (Saipan)

The medical plan covers eligible expenses for covered health services. See the “Covered health services definition” section starting on page 2-49 and the “Eligible expenses (allowed amount) definition” section starting on page 2-49 for more information. You may choose any doctor or hospital; however, if you are able to receive services from an in-network provider, you can take advantage of network discounted rates.

When you receive services under the Indemnity Medical Plan — Anthem BCBS:

• You pay 100% of eligible expenses for covered health services until you satisfy the annual deductible.
• After you satisfy the annual deductible, you pay 20% coinsurance for eligible expenses for covered health services (except for prescription drugs; see the “Prescription drug benefit” section starting on page 2-127 for information about what you will pay for prescription drugs).
• The medical plan pays 100% of eligible expenses for eligible preventive care services (there is no annual deductible to satisfy).
• You pay a copay for generic prescription drugs or coinsurance for brand-name drugs; see the “Prescription drug benefit” section starting on page 2-127.
• You must contact the claims administrator to receive the required pre-service authorizations for certain services (see the “Pre-service authorization requirements” section starting on page 2-44) before receiving those services.
• For services received from an out-of-network provider, you pay 100% of expenses above those considered eligible expenses. An out-of-network provider can bill you for all expenses the plan does not cover, including those above the eligible expense (or allowed amount) and you are responsible for payment to the out-of-network provider.
• You pay 100% for services or expenses not covered by 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 the claims administrator’s associated networks.
• You are required to pay an out-of-network provider and file a claim for reimbursement (see the “Claims and appeals” section starting on page 2-119 for more information).
• After you satisfy your annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services for which coinsurance would apply. However, you will continue to pay prescription drug expenses up to the separate in-network individual or family prescription drug annual out-of-pocket maximum even if the medical plan annual out-of-pocket maximum has been met.

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

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

• Your annual deductible would be $300.
• Your annual out-of-pocket maximum would be $2,300.

Expenses incurred in a previous plan year or before the effective date of medical coverage under the Wells Fargo & Company Health Plan do not count toward the annual deductible or annual out-of-pocket maximum.

The above information applies to midyear enrollment in the Indemnity Medical Plan — Anthem BCBS by newly hired or rehired team members, team members who are newly benefits-eligible due to an employment classification change, and team members who newly enroll because of a special enrollment right (see the “Special enrollment rights” section in “Chapter 1: An Introduction to Your Benefits”) or because of an allowable Qualified Event (see the “Qualified Events” section in “Chapter 1: An Introduction to Your Benefits”). The above information also applies to a covered dependent of a team member who enrolls in the Indemnity Medical Plan — Anthem BCBS midyear as a COBRA-qualified beneficiary. The above information does not apply to certain rehired retirees (see the “Rehired retirees” section on page 2-31).

Rehired COBRA participants

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

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

- Your in-network annual deductible would be $300.
- Your in-network annual out-of-pocket maximum would be $2,300.

As a rehired team member who had continuous COBRA medical coverage and enrolled in the Indemnity Medical Plan — Anthem BCBS during a rehire enrollment period, the following will be applied to your Indemnity Medical Plan — Anthem BCBS coverage as a team member under the Wells Fargo & Company Health Plan:

- Amounts previously applied to your current year’s COBRA annual deductible and annual out-of-pocket maximum will apply to your new Indemnity Medical Plan — Anthem BCBS annual deductible and annual out-of-pocket maximum for the same plan year (for eligible expenses incurred by you or eligible dependents that you covered under your COBRA medical coverage under the Wells Fargo & Company Health Plan and who remain covered under the Indemnity Medical Plan — Anthem BCBS benefit option of the Wells Fargo & Company Health Plan).
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.

**Rehired retirees**

This section applies to you if you are a retiree who is rehired by Wells Fargo & Company, who had retiree medical coverage under the Wells Fargo & Company Retiree Plan immediately preceding your date of rehire, and you elect the Indemnity Medical Plan — Anthem BCBS benefit option under the Wells Fargo & Company Health Plan as a rehired team member.

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

- Your in-network annual deductible would be $300.
- Your in-network annual out-of-pocket maximum would be $600.

As a rehired retiree who had retiree medical coverage under the Indemnity Medical Plan — Anthem BCBS benefit plan option under the Wells Fargo & Company Retiree Plan immediately preceding your date of rehire and who elects the Indemnity Medical Plan — Anthem BCBS benefit option under the Wells Fargo & Company Health Plan as a rehired team member, the following will be applied to your Indemnity Medical Plan — Anthem BCBS coverage as a team member under the Wells Fargo & Company Health Plan:

- Amounts previously applied to your current year’s retiree annual deductible and annual out-of-pocket maximum will apply to your new Indemnity Medical Plan — Anthem BCBS Medical Plan annual deductible and annual out-of-pocket maximum for the same plan year (for eligible expenses incurred by you or eligible dependents that you covered under the Indemnity Medical Plan — Anthem BCBS benefit option of the Wells Fargo & Company Health Plan).
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.

If your retiree medical coverage under the Wells Fargo & Company Retiree Plan was an option other than the Indemnity Medical Plan — Anthem BCBS, none of your previous expenses under the Wells Fargo & Company Retiree Plan will be credited toward the annual deductible or annual out-of-pocket maximum for the Indemnity Medical Plan — Anthem BCBS under the Wells Fargo & Company Health Plan.

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

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

Expenses incurred in a previous plan year or before the effective date of medical coverage in the Wells Fargo & Company Health Plan do not count toward the annual deductible or annual out-of-pocket maximum.
**COBRA enrollment**

If you are eligible for and elect COBRA continuation coverage for the Indemnity Medical Plan — Anthem BCBS during your initial COBRA enrollment period at the same level of coverage you had under the Indemnity Medical Plan — Anthem BCBS as a benefits-eligible team member, eligible covered expenses previously applied to the current year’s annual deductible and annual out-of-pocket maximum for you, under your team member Indemnity Medical Plan — Anthem BCBS coverage, will apply to your Indemnity Medical Plan — Anthem BCBS COBRA continuation coverage for the same plan year.

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

If your dependent is no longer eligible for coverage under your Indemnity Medical Plan — Anthem BCBS coverage and elects COBRA medical coverage (separate from you) under the Wells Fargo & Company Health Plan during the year, any charges that were incurred by the dependent and applied toward the current year annual deductible and annual out-of-pocket maximum under your previous team member 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 Wells Fargo & Company Health Plan. Also see the “Annual deductible and annual out-of-pocket maximum for midyear enrollments” section on page 2-30 for other information related to a midyear enrollment.

Lifetime benefits accruals for infertility and fertility services and treatment will transfer to the Indemnity Medical Plan — Anthem BCBS COBRA continuation coverage for any individual who has COBRA continuation coverage.

**Midyear change in medical plan benefit option**

If you move

If you have a change in residential address during the year, your previous medical plan benefit option may not be available to you (such as an HMO — Kaiser or HDHP — Kaiser medical plan, the HRA-Based Medical Plan, the HSA-Based Medical Plan — Gold, or the HSA-Based Medical Plan — Silver), depending on where you move. If you elect to enroll in the Indemnity Medical Plan — Anthem BCBS midyear as a result of your change in residential address, please refer to the “Annual deductible and annual out-of-pocket maximum for midyear enrollments” section on page 2-30 for more information.

If you have a special enrollment right or Qualified Event

If you enroll in the Indemnity Medical Plan — Anthem BCBS midyear as a result of a special enrollment right or an eligible Qualified Event, please refer to the “Annual deductible and annual out-of-pocket maximum for midyear enrollments” section on page 2-30 for more information.

**When you retire**

When you retire, your Indemnity Medical Plan — Anthem BCBS coverage under the Wells Fargo & Company Health Plan terminates at the end of the month in which you retire.

If you do not elect the Indemnity Medical Plan — Anthem BCBS coverage under the Wells Fargo & Company Retiree Plan, the claims administrator will continue to process any eligible medical claims incurred before the termination of coverage and filed within 12 months of the date of service.

Refer to “Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare” in the **Retiree Benefits Book**, available on **Teamworks**, for information about electing the Indemnity Medical Plan — Anthem BCBS coverage (or another coverage option, if applicable) under the Wells Fargo & Company Retiree Plan as a retiree. If you or a covered dependent are eligible for Medicare at the time you retire, refer to “Chapter 3: Medical Plans for Retirees Eligible for Medicare” in the **Retiree Benefits Book**, available on **Teamworks**, for information about your enrollment options.

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

Coverage ends as described in the “When coverage ends” section in “Chapter 1: An Introduction to Your Benefits.” You may be eligible to elect COBRA continuation coverage for the Indemnity Medical Plan — Anthem BCBS 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 Indemnity Medical Plan — Anthem BCBS, see the “COBRA enrollment” section on this page.
If you elect another medical benefit option at any time or otherwise elect to drop your Indemnity Medical Plan — Anthem BCBS coverage, your coverage under the Indemnity Medical Plan — Anthem BCBS will end; however, the claims administrator will continue to process any eligible medical claims incurred prior to the termination of coverage and filed within the claims filing period.

If your dependent is no longer eligible for coverage and elects COBRA continuation coverage under the Indemnity Medical Plan — Anthem BCBS, see the “Annual deductible and annual out-of-pocket maximum for midyear enrollments” section on page 2-30 for more information. If your dependents become eligible for their own individual coverage under COBRA, any charges that were incurred by them and applied toward the previous annual deductible under your coverage do not count toward the dependent's applicable annual deductible and annual out-of-pocket maximum as a result of their COBRA enrollment.

Indemnity Medical Plan — Anthem BCBS: annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the Indemnity Medical Plan — Anthem BCBS and are subject to the procedures, exclusions, and limitations in this chapter. Refer to the “Prescription drug benefit” section starting on page 2-127 for information about how prescription drugs are covered, including a separate and distinct in-network prescription drug out-of-pocket maximum.

This plan is only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan).

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Your annual deductible responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>$300</td>
</tr>
<tr>
<td>You + spouse*</td>
<td>$600</td>
</tr>
<tr>
<td>You + children</td>
<td>$600</td>
</tr>
<tr>
<td>You + spouse* + children</td>
<td>$600</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Your annual out-of-pocket maximum responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>$2,300</td>
</tr>
<tr>
<td>You + spouse*</td>
<td>$4,600</td>
</tr>
<tr>
<td>You + children</td>
<td>$4,600</td>
</tr>
<tr>
<td>You + spouse* + children</td>
<td>$4,600</td>
</tr>
</tbody>
</table>

* For the purposes of this chapter, the term “spouse” includes your domestic partner, unless otherwise noted.
Health and wellness activities

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

If you enroll in the HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, the HSA-Based Medical Plan – Silver, or an HDHP — Kaiser medical plan, you and your covered spouse or domestic partner have an opportunity to participate in health and wellness activities associated with the health plans. In addition, you and your covered spouse or domestic partner can earn health and wellness dollars for your health savings account or health reimbursement account, as applicable, when you complete certain health and wellness-related activities. In order to participate in these health and wellness activities and earn health and wellness dollars, you and your covered spouse or domestic partner must be at least 18 years of age. (Covered dependent children are not eligible to participate in health and wellness activities or to earn health and wellness dollars regardless of age.)

You and your covered spouse or domestic partner cannot receive health and wellness dollars for repeating the same activity or program during this same plan year. In addition, you and your covered spouse or domestic partner may only earn health and wellness dollars for one completed “Take action” program each plan year. More than one program or activity may be completed during the plan year without earning additional health and wellness dollars.

The health and wellness dollars may be used for covered health services only after the health and wellness dollars have been allocated to your applicable health savings account or health reimbursement account. Health and wellness dollars will not be applied retroactively to claims that have been processed before the health and wellness dollars were allocated to your applicable account.

Note: For purposes of the information to follow in this “Health and wellness activities” section only, “you” includes you and your covered spouse or domestic partner.

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

Note: Health and wellness dollars are not available to participants of the Indemnity Medical Plan — Anthem BCBS, HMO — Kaiser medical plans, or POS Kaiser Added Choice — Hawaii.

Optum is the administrator of all health and wellness activities that allow you and a covered spouse or domestic partner to earn health and wellness dollars. Listed on the following page are the specific activities, the maximum amount of health and wellness dollars that can be earned, and additional requirements for earning health and wellness dollars. You must complete the applicable health and wellness activity between January 1, 2018, and November 15, 2018, to earn health and wellness dollars for the 2018 plan year.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Team member only</th>
<th>Team member plus spouse or domestic partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get started</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Castlight¹</td>
<td>• Form a Care Team (or add a provider to your Care Team)</td>
<td>• $25 each ($50 total) for forming or adding a provider to your Care Team</td>
</tr>
<tr>
<td></td>
<td>• Watch videos on Castlight</td>
<td>• $75 each ($150 total) for watching up to four videos</td>
</tr>
<tr>
<td></td>
<td></td>
<td>You and your covered spouse or domestic partner may each earn health and wellness dollars for forming a Care Team on Castlight for the first time, or for adding a provider to your existing Care Team. Forming a Care Team on Castlight is a convenient way to have all of your health care providers and their contact information in one place. You can earn additional health and wellness dollars by watching up to four videos on the Castlight site. These videos provide education on a variety of topics to help you understand health care and your benefits.</td>
</tr>
<tr>
<td>Health survey</td>
<td>$25</td>
<td>$25 each ($50 total)</td>
</tr>
<tr>
<td></td>
<td>Complete a voluntary health survey that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (for example, cancer, diabetes, or heart disease).</td>
<td></td>
</tr>
<tr>
<td>Know your numbers</td>
<td>Biometric screening</td>
<td>$325 each ($650 total)</td>
</tr>
<tr>
<td></td>
<td>Complete a voluntary biometric screening at a Wells Fargo on-site event, through your personal physician (preferably at the time of your annual preventive exam), or at a MinuteClinic² location, where available (including blood pressure screening, cholesterol, blood glucose, body mass index, and self-reported tobacco use).</td>
<td></td>
</tr>
</tbody>
</table>

1. HDHP — Kaiser members do not have access to Castlight. To earn the associated health and wellness dollars, HDHP — Kaiser members will attest to reading two articles on the Rally Health Portal. More information can be found in the “Who’s eligible to earn health and wellness dollars?” section on page 2-37.

2. HDHP — Kaiser members do not have access to MinuteClinic locations and must obtain their biometric screening through their personal physician or at a Wells Fargo on-site event.
Activity | Team member only | Team member plus spouse or domestic partner
--- | --- | ---
**Take action**
Complete one of the following programs of your choice to help you reach your health and wellness goals. Each option consists of multiple sessions over a number of weeks.

Choose from:

- **Telephonic Wellness Coaching**
  Complete a minimum of three calls on one of the following topics:
  - Exercise
  - Nutrition
  - Weight management
  - Diabetes lifestyle
  - Stress management
  - Healthy lifestyle
  - Tobacco cessation

- **Maternity Support Program**
  Complete a minimum of three calls

- **Condition Management Program**
  (administered through your health plan)
  Complete a minimum of three calls if you have one of the following conditions:
  - Asthma
  - Diabetes
  - Coronary artery disease
  - Heart failure
  - COPD

- **Rally Missions**
  Complete any three interactive online missions on the Rally portal.

**Total health and wellness dollars available** | $800 maximum | $1,600 maximum
--- | --- | ---

3. HDHP — Kaiser members will not earn health and wellness dollars for a Maternity Support program. To earn the associated health and wellness dollars, HDHP — Kaiser members must complete Telephonic Wellness Coaching or Rally Missions. More information can be found in the “Health and wellness activities” section starting on page 2-37.

4. HDHP — Kaiser members will not earn health and wellness dollars for Condition Management programs. To earn the associated health and wellness dollars, HDHP — Kaiser members must complete Telephonic Wellness Coaching or Rally Missions. More information can be found in the “Health and wellness activities” section starting on page 2-37.
The amounts stated in the tables on pages 35 and 36 reflect the maximum amount of health and wellness dollars available for deposit in your health savings account or allocated to your health reimbursement account, as applicable, upon completion of the specified health and wellness activities. These amounts will be prorated for midyear enrollments and may be prorated for midyear status changes that affect your level of coverage. In certain cases, these amounts may be reduced due to legal limitations imposed under applicable law or program administration provisions (even if you and your covered spouse or domestic partner complete the required health and wellness activities).

- For the earned health and wellness dollars to be allocated to your health reimbursement account, you must be a participant in the HRA-Based Medical Plan at the time the activity is completed.
- For the earned health and wellness dollars to be deposited into your health savings account:
  - You must be a participant in the HSA-Based Medical Plan – Gold, HSA-Based Medical Plan – Silver, or an HDHP – Kaiser medical plan at the time the activity is completed.
  - You must have an open health savings account with Optum Bank for the plan year in which health and wellness dollars were earned and the health savings account must be open on the date the health and wellness dollars are to be deposited.
  - You must be eligible for additional health savings account contributions.

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

You and your covered spouse or domestic partner cannot receive health and wellness dollars for repeating the activities or programs during this same plan year. In addition, you or your covered spouse or domestic partner may only earn health and wellness dollars for one completed “Take action” program each plan year, even if you complete more than one program.

Who’s eligible to earn health and wellness dollars?

To be eligible to earn health and wellness dollars, you must be enrolled in one of the following plans: the HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, the HSA-Based Medical Plan – Silver, or an HDHP – Kaiser medical plan under the Wells Fargo & Company Health Plan. Only you and your covered spouse or domestic partner are eligible to earn health and wellness dollars. In order to participate in health and wellness activities and earn health and wellness dollars, you and your covered spouse or domestic partner must be at least 18 years of age. You are also eligible to earn health and wellness dollars if you have elected COBRA coverage or are on an approved leave of absence.

Note: You and your spouse or domestic partner are only able to complete the health and wellness activities after your medical coverage effective date.

Covered dependent children are not eligible to participate in health and wellness activities or to 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.

Health and wellness activities

The various health and wellness activities and programs you can choose from that allow you to earn health and wellness dollars for your applicable account-based medical plan are described below. You are not required to complete the health and wellness activities, as the wellness program is voluntary; however, only team members who complete the activities will receive health and wellness dollars.

The Rally Health Portal, brought to you by Optum, will help you monitor completion of these activities and the health and wellness dollars you’ve earned. Access to this portal is provided through wellness.myoptumhealth.com, Teamworks, Teamworks at Home, or Castlight.

Health survey (Get started)

The health survey is an online tool that takes about 15 minutes to complete and can help you understand where your health and wellness stand today. In return, you’ll get a “Rally Age” and health profile that shows where you are compared with other people of your age and gender. This information will help create a plan to start living a healthier lifestyle. You are also encouraged to share your results or concerns with your own doctor.
The health survey can be completed on the Rally Health Portal January 1, 2018, through November 15, 2018. Access to this portal is provided through wellness.myoptumhealth.com, Teamworks, Teamworks at Home, or Castlight. If you do not have online access to a computer, a paper copy of the health survey may be requested by calling Optum at 1-877-543-4294.

**Castlight (Get started)**

Castlight is a cost transparency tool designed to help team members, their covered spouses or domestic partners, and their adult dependents enrolled in Wells Fargo account-based medical plans. Information on Castlight helps team members understand their plans and make informed choices by comparing provider quality ratings and costs.

Team members and their enrolled spouses or domestic partners can earn health and wellness dollars for using Castlight by:

- Forming a Care Team on Castlight, or adding a provider to an existing Care Team
- Watching up to four videos on the Castlight website

Health and wellness dollars may be earned by performing these steps between January 1 and November 15, 2018.

Access to Castlight is provided through mycastlight.com/wf, Teamworks, Teamworks at Home, or the Rally Health Portal.

* HDHP – Kaiser members do not have access to Castlight and may earn the equivalent health and wellness dollars by attesting to have read two articles on the Rally Health Portal at wellness.myoptumhealth.com.

**Biometric screenings (Know your numbers)**

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 will, through a simple blood draw, determine your cholesterol and blood glucose (sugar) levels. You are encouraged to share your results or concerns with your own doctor. You will also be asked to certify your tobacco-use status.

Biometric screenings can be completed in one of three ways:

- Participate in one of the on-site screening events provided by Optum, held at select larger work sites (on-site screening events are for team members only).
- Receive your screening from your personal physician.
- Visit a MinuteClinic location, if available, and receive your screening. (HDHP – Kaiser members do not have access to MinuteClinic locations and must obtain their screening through their personal physician or at an on-site screening event.)

Note: While it is intended that a biometric screening you receive from your personal physician will be an eligible preventive care service under the HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, the HSA-Based Medical Plan – Silver, and an HDHP – Kaiser medical plan, whether your biometric screening is in fact treated as an eligible preventive care service will depend solely on how your physician codes the claim. Once the claim is filed, the claim will be processed based on how your provider coded the claim. For more information on eligible preventive care services, see the “Preventive care services (eligible preventive care services)” section starting on page 2-99.

For screenings received from your physician, the medical provider will need to complete a Health Provider Screening form and you or your physician will need to submit the completed and signed form to Optum.

For screenings received at a MinuteClinic, you will need to submit the completed and signed medical Health Provider Screening form to Optum. The MinuteClinic provider is not able to submit the form to Optum on your behalf. There should be no cost to you for a biometric screening received at a MinuteClinic.

You can obtain a copy of the Health Provider Screening form through wellness.myoptumhealth.com. In order to earn 2018 health and wellness dollars for a biometric screening received from your personal physician or at a MinuteClinic, you must receive your biometric screening between January 1, 2018, and November 15, 2018, while covered under a Wells Fargo account-based medical plan. The completed and signed Health Provider Screening form must be submitted to Optum no later than December 31, 2018. Submit your completed and signed Health Provider Screening form directly to Optum. You have the option to upload the form by visiting wellness.myoptumhealth.com, fax it to 1-888-608-2010, or mail it to:

Optum
4205 Westbrook Drive
Aurora, IL 60504

It is your responsibility to ensure that your provider completes the Health Provider Screening form correctly and that the Health Provider Screening form is timely submitted to Optum. Forms with a postmark or a fax received date after December 31, 2018, will not be accepted.

Note: Biometric screenings received between November 16, 2017, and December 31, 2017, will not be eligible for 2018 health and wellness dollars.
You may receive a phone call from Optum or your medical plan’s claims administrator to invite you to participate in a program that can help meet your personal health needs. Your participation is entirely voluntary.

**Telephonic wellness coaching (Take action)**

These telephonic wellness coaching sessions may help you to better understand and manage certain lifestyle risks and health conditions. You must successfully complete at least three telephonic coaching sessions to earn applicable health and wellness dollars.

Choose from the following telephonic wellness coaching options:

- Weight management
- Diabetes lifestyle
- Exercise
- Heart health lifestyle
- Nutrition
- Stress management
- Tobacco cessation

More information can be found on the Rally Health Portal and may be accessed through wellness.myoptumhealth.com, Teamworks, Teamworks at Home, or Castlight.

**Maternity support (Take action)**

If you are pregnant, you can receive educational information and tips for a healthy pregnancy. Pregnant team members or enrolled spouses and domestic partners may earn health and wellness dollars by completing three sessions in the maternity support program.* Contact your claims administrator as early in your pregnancy as possible to participate in the program.

* HDHP — Kaiser members cannot earn health and wellness dollars for the maternity support program.

**Condition management (Take action)**

The claims administrators provide responsive disease management programs that identify, assess, and support members with specific chronic conditions. Chronic condition support is available for:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Diabetes
- Heart failure

Team members and enrolled spouses and domestic partners who have one of the above mentioned conditions may earn health and wellness dollars by completing three sessions in the condition management program.*

* HDHP — Kaiser members cannot earn health and wellness dollars for condition management programs.

**Rally Missions (Take action)**

Rally Missions (“Missions”) are online wellness programs designed to help you improve your daily health habits and behaviors while educating you about certain health topics. Your may choose from a variety of Missions that fall into the following categories:

- Eat
- Move
- Feel
- Care

Missions consist of a series of tasks to complete over several weeks. You must successfully complete three separate Missions to earn the applicable health and wellness dollars.

Missions can be found on the Rally Health Portal, and can be completed starting January 1, 2018, through November 15, 2018. Access to this portal is provided through wellness.myoptumhealth.com, Teamworks, Teamworks at Home, or Castlight.

**Health and wellness dollar disputes**

Call Optum at 1-877-543-4294 if it has been more than 30 days since either of the following has occurred and the applicable earned health and wellness dollars have not been deposited into your applicable health reimbursement account or health savings account:

- You completed the online or telephonic programs, on-site biometric screening performed by Optum (in certain Wells Fargo locations), health assessment, or Castlight activities.
- Optum received your complete and accurate Health Provider Screening form if you had your biometric screening performed by your doctor or at a MinuteClinic location and not at the on-site biometric screening performed by Optum (in certain Wells Fargo locations).

Optum may deem it necessary for you to file a written inquiry. If so, they will provide you with the appropriate form. For 2017 health and wellness dollars, your inquiry must be submitted to Optum no later than June 30, 2018. Inquiries for 2017 health and wellness dollars received later than June 30, 2018, will be denied.
Optum will issue a written response within 30 days of the Optum Customer Service Team’s receipt of your inquiry. If Optum approves your written inquiry, applicable health and wellness dollars will be deposited into your HRA or HSA as applicable. If Optum denies your inquiry, your written response will include information about the appeals process, including how to file an appeal.

If you have any questions, call the Optum Portal Support Team at 1-877-543-4294.

Please 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 HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, the HSA-Based Medical Plan – Silver, and an HDHP – Kaiser medical plan are participatory wellness programs and do not require you to achieve particular health outcomes. There may be situations where you are unable to complete a biometric screening 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 a biometric screening to earn health and wellness dollars, you may fax a request for accommodations to Optum at 1-888-608-2010. You must complete the Health Provider Screening Accommodation form that can be found on Teamworks or the Rally Health Portal and may be accessed through wellness.myoptumhealth.com from Teamworks and Teamworks at Home. For 2018 health and wellness dollars, the Health Provider Screening Accommodation form must be submitted no later than December 31, 2018.

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 will 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 would also 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.

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 Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2.

Other programs, tools, and resources
Optum and the claims administrators for the HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, and the HSA-Based Medical Plan – Silver offer additional programs, tools, and resources to help team members and covered dependents better manage their health and make healthier lifestyle choices. These resources are voluntary, confidential, and available at no additional cost to team members and covered dependents. Optum provides telephonic wellness coaching, and web-based tools and resources, including online wellness education programs, through their Rally Health Portal. Each of these is described in more detail below.
The medical claims administrators, CVS Caremark, and Optum work together as part of an integrated health management program to provide resources to support your health. The programs and services offered may include education about a condition or individual support from a nurse. You may also receive an outreach call to enroll in a telephonic wellness coaching program or other programs offered through your claims administrator. Participation in these programs is voluntary. These services are offered at no cost to participants and are described below.

Some of these additional programs, tools, and resources are available to team members enrolled in the Indemnity Medical Plan — Anthem BCBS in Puerto Rico. The only resource available to team members enrolled in the Indemnity Medical Plan — Anthem BCBS in Guam and the Northern Mariana Islands (Saipan) is the Anthem BCBS 24-hour NurseLine.

24-hour NurseLine
Nurses are available 24 hours a day, 365 days a year to deliver symptom decision support, evidence-based health information and education, and medication information.

- **UnitedHealthcare**: Call NurseLine at 1-877-440-9402.
- **Anthem BCBS**: Call NurseLine at 1-866-220-4849.
- **HealthPartners**: Call CareLine at 1-800-551-0859.

**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.

**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.

**Medical specialty drugs administered by a medical provider (Anthem BCBS 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 or in your home by a home infusion provider. 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 will give the results of our 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 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 Anthem BCBS to verify specialty drug coverage, to find out which drugs are covered under this section and if precertification is required.
Real Appeal program (for Anthem BCBS, HealthPartners, and UHC only)

Real Appeal is a weight loss program administered by UnitedHealthcare 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 at no additional cost to eligible team members, spouses, domestic partners, and adult dependents (18 – 26) with a Body Mass Index (BMI) of 23 or greater and who are enrolled in a Wells Fargo medical plan administered by UnitedHealthcare, Anthem, or HealthPartners. Real Appeal is not available to individuals enrolled in the Kaiser medical plans.

Real Appeal is an intensive, multicomponent weight loss program that provides a 52-week virtual approach that includes online group participation with supporting video content, delivered by a live virtual coach, and one-on-one coaching for individuals with a BMI of 30 or greater or a BMI of 23 – 29.9 and an associated condition (for example, high blood pressure or diabetes). The experience will be personalized for each person. This program may include, but is not limited to, the following:

- Online support and self-help tools: group support sessions, including integrated telephonic support, and mobile applications
- Education and training materials focused on goal setting, problem-solving skills, barriers, and strategies to maintain changes
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss

Participation is completely voluntary and without any additional charge or cost-share. There are no copays, coinsurance, or deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit realappeal.com.
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 HealthPartners, 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.

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. 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 HealthPartners, certain outpatient surgeries), the plan pays 100% of eligible expenses after you satisfy the annual deductible.

No coverage for inpatient services received from out-of-network providers. The plan pays 60% of eligible expenses after you satisfy the annual deductible for outpatient services received from out-of-network providers.

Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant’s spine (back) and joint (knees and hips) inpatient surgery (or for HealthPartners, certain outpatient surgeries).

<table>
<thead>
<tr>
<th>Description</th>
<th>Anthem BCBS*</th>
<th>HealthPartners</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-hour NurseLine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>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</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Autism Spectrum Disorder (ASD) Support</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>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</td>
<td>X</td>
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<tr>
<td>Bariatric surgery support</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Provides clinical support before and after weight loss surgery</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Cancer support</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Nurses provide support services to help those dealing with cancer</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Complex case management</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nurses provide support for those dealing with serious and complex health issues</td>
<td>X</td>
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<tr>
<td>Disease management</td>
<td>X</td>
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<tr>
<td>Helps those with a chronic medical condition such as asthma, diabetes, and heart disease to better understand and manage those conditions</td>
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<tr>
<td>Maternity support</td>
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<tr>
<td>Program to support normal and high-risk pregnancies</td>
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<tr>
<td>Medical Rx specialty management</td>
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<td>Real Appeal program</td>
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<td>Orthopedic treatment decision support</td>
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<td>For eligible spine (back) and joint (knees and hips) inpatient surgery (or for HealthPartners, certain outpatient surgeries)</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Web-based tools and resources</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Online tools, resources, and programs that can help you make healthier lifestyle choices</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

* For the Indemnity Medical Plan — Anthem BCBS, these additional programs, tools, and resources are available to team members in Puerto Rico. The only resource available to team members enrolled in the Indemnity Medical Plan — Anthem BCBS in Guam and the Northern Mariana Islands (Saipan) is the Anthem BCBS 24-hour NurseLine. There are no health and wellness dollars associated with any health and wellness activities or resources.

Check with your applicable claims administrator for program specifics.

Chapter 2: Medical Plans 2-43
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 HRA-Based Medical Plan, you cannot use your HRA dollars to pay for these charges.

If you do not receive the required authorization or approval before the following out-of-network services are received, your benefits will be reduced by 20% of eligible expenses if the claims administrator determines the services are covered health services:

- Dental care services and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
- Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item)
- Home health care services
- Home infusion therapy services
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Transplant services

The 20% reduction does not count toward the annual deductible or the annual out-of-pocket maximum. And, if you are enrolled in the HRA-Based Medical Plan, you cannot use your HRA dollars to pay for the additional 20% that becomes your responsibility.

When you request pre-service authorization for a nonurgent care service, the claims administrator will make an initial determination within 15 calendar days as long as all information reasonably needed to make a decision has been provided. This time period may be extended for an additional 15 calendar days, provided that the claims administrator determines that such extension is necessary due to matters beyond its control. If such extension is necessary, you will be notified before the expiration of the initial 15-day period.

When you request pre-service authorization for an urgent care service, the claims administrator will make an initial determination within 72 hours, as long as all information reasonably needed to make a decision has been provided. If you have not provided all necessary information, you will be notified of this within 24 hours. You will then be given 48 hours to provide the requested information. You will be notified of the benefit determination within 48 hours after the claims administrator receives the complete information or at the end of the time granted to the claimant to provide the specified additional information, whichever is earlier.

More information on pre-service authorizations (pre-service claims) can be found in “Appendix A: Claims and Appeals” in this Benefits Book.

Each claims administrator has a list of services that are subject to pre-service authorization. Refer to the list below or contact your claims administrator for information about what services may require pre-service authorization.

UnitedHealthcare

For pre-service authorization, contact UnitedHealthcare at 1-800-842-9722. Pre-service authorization is subject to UnitedHealthcare medical policy located at myuhc.com. Generally, medical policy is based on medically necessary criteria, which are described below.

Medically necessary – health care services provided for the purpose of preventing, evaluating, diagnosing, or treating a sickness, injury, mental illness, substance use disorder, condition, disease, or its symptoms, that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare’s sole discretion. The services must be all of the following:

- In accordance with Generally Accepted Standards of Medical Practice.
Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician Specialty Society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply Physician Specialty Society recommendations, the choice of expert, and the determination of when to use any such expert opinion shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting its determinations regarding specific services.

- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for your sickness, injury, mental illness, substance use disorder, disease, or its symptoms.
- Not mainly for your convenience or that of your doctor or other healthcare provider.
- Not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease, or symptoms.

The following list of services is subject to pre-service authorization to ensure services meet coverage criteria. This list of services is subject to change in accordance with UnitedHealthcare medical policy. You may also call UnitedHealthcare Member Services for the most current list.

- Approved fetal interventions
- Arthroscopy
- Bariatric surgery
- BRCA testing (genetic testing for breast cancer susceptibility)
- Cancer treatment services received through the Cancer Resource Services program
- Cardiac imaging or stress tests
- Cardiac rehabilitation services
- Certain spine (back) and joint (knees and hips) procedures
- Clinical trials
- Congenital heart disease services under the Congenital Heart Disease (CHD) services program
- Congenital heart disease surgical interventions
- CT or CAT scans
- Dental and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth; temporomandibular joint (TMJ) surgical procedures; and orthognathic surgery
- Diagnostic cardiac catheterization
- Dialysis (outpatient)
- Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
- Electrophysiology implant
- Extended skilled nursing services
- Fetal echocardiograms
- Heart catheterization
- Home health care services
- Home infusion therapy services
- Hospice care
- Hysterectomy
- Infertility and fertility services and treatments
- Inflammatory injectable medications
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Intensity modulated radiation therapy
- Interventional cardiac catheterizations
- Maternity services if stay exceeds the 48-hour or 96-hour guidelines (including stays for a newborn that continue after the mother has been discharged)
- MR-guided focused ultrasound
- MRI or MRA scans
- Nonemergent ambulance services
- Nuclear medicine services
- Oncology services received through the Cancer Resource Services program
• Out-of-network outpatient surgery
• Outpatient sleep studies, including associate lab and x-ray services
• PET scans
• Prescription drugs that require administration under the direct supervision of a health care professional
• Prosthetic device that costs $1,000 or more
• Reconstructive surgery
• Sinuplasty
• Skilled nursing facility stays
• Sleep apnea procedures and surgeries
• Temporomandibular joint (TMJ) disorder surgery
• Therapeutics (outpatient)
  – Dialysis
  – IMRT
  – MR-guided focused ultrasound
  – IV infusion
  – Radiation oncology
• 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 UnitedHealthcare pre-service authorization procedures for the following out-of-network services will result in a 20% reduction of the amount otherwise payable for eligible services:

• Dental care services and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
• Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
• Home health care services
• Home infusion therapy services
• Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
• Transplant services

The 20% reduction does not count toward the annual deductible or the annual out-of-pocket maximum. And, if you are enrolled in the HRA-Based Medical Plan, you cannot use your HRA dollars to pay for the additional 20% that becomes your responsibility.

Anthem BCBS
For pre-service authorization, contact Anthem BCBS at 1-866-418-7749 or by fax at 1-800-241-5308. It is recommended that you or the provider contact Anthem BCBS at least 15 business days before receiving the care to determine if the services are eligible.

Anthem reserves the right to determine whether a service or supply is medically necessary. The fact that a physician has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it medically necessary. Anthem considers a service medically necessary if it meets all the following conditions:

• Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient’s condition.
• Compatible with the standards of acceptable medical practice in the United States.
• Not provided solely for your convenience or the convenience of the physician, health care provider, or hospital.
• Not primarily custodial care.
• Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

The following list of services is subject to pre-service authorization to ensure services meet coverage criteria. This list of services is subject to change in accordance with Anthem BCBS medical policy located at anthem.com. You may also call Anthem BCBS Member Service for the most current list.

• Acute inpatient rehabilitation
• Bariatric procedures
• Carotid, vertebral, and intracranial artery angioplasty with or without stent placement
• Certain spine (back) and joint (knees and hips) procedures
• Cord blood, peripheral stem cell, and bone marrow procedures
• Cryosurgical ablation of solid tumors outside the liver
• CT or CAT scans
• Dental and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
• Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
• Extended skilled nursing care
• Home health care services
• Home infusion therapy services
• Hospice care (inpatient and outpatient)
• Infertility and fertility services and treatments
• Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
• Intensity Modulated Radiation Therapy (IMRT)
• Long-term acute care facilities
• Maternity services if stay exceeds the 48 hours for normal delivery and 96 hours after a cesarean delivery
• MRA, MRI, or MRS scans
• Nuclear or cardiac imaging
• PET scans
• Proton beam therapies
• Radiofrequency ablation to treat tumors outside the liver
• 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
• Transplant services

You are required to obtain pre-service authorization for the services listed below before receiving these services from an out-of-network provider. Failure to follow the Anthem BCBS pre-service authorization procedures for the following out-of-network services will result in a 20% reduction of the amount otherwise payable for eligible services:
• Dental care services and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
• Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
• Home health care services
• Home infusion therapy services
• Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
• Transplant services

The 20% reduction does not count toward the annual deductible or the annual out-of-pocket maximum. And, if you are enrolled in the HRA-Based Medical Plan, you cannot use your HRA dollars to pay for the additional 20% that becomes your responsibility.

HealthPartners
Pre-service authorization is subject to HealthPartners medical policies located at healthpartners.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 HealthPartners, 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 HealthPartners.
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 healthpartners.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. If you are receiving your care out-of-network, it is your responsibility to notify CareCheck at 952-883-6400 or 1-800-316-9807 for pre-certification to ensure services meet coverage criteria.

- Bariatric surgery
- Blepharoplasty or ptosis repair
- Certain spine (back) and joint (knees and hips) procedures
- Continuous passive motion devices (after 42 days of rental)
- Dental and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
- Durable medical equipment that costs $1,000 or more and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
- Eye surgery — refractive (including Intacs)
- Habilitative therapy: speech, physical, and occupational therapy
- Home health care services
- Home infusion therapy services
- Hospital beds (starting with the fourth month of rental and prior to the purchase of the item)
- Infertility and fertility services and treatments
- Injectable drugs administered in a clinic
- Injections for low back pain
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Mobile cardiac outpatient monitoring and implantable loop recorders
- New technology
- Reconstructive surgery
- Sclerotherapy
- Skilled nursing facility stays
- Transplant services
- Uvulopalatoplasty (UPPP)
- Wheelchairs (starting with the fourth month of rental for manual wheelchairs)

CareCheck
You are required to obtain pre-service authorization for the services listed below before receiving these services from an out-of-network provider. For pre-service authorization, contact HealthPartners CareCheck at 952-883-6400 or 1-800-316-9807. Failure to follow the CareCheck pre-service authorization procedures for the following out-of-network services will result in a 20% reduction of the amount otherwise payable for eligible services:

- Dental care services and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth, temporomandibular joint (TMJ) surgical procedures, and orthognathic surgery
- Durable medical equipment that costs $1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase or cumulative rental of a single item)
- Home health care services
- Home infusion therapy services
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), or within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Transplant services

The 20% reduction does not count toward the annual deductible or the annual out-of-pocket maximum. And, if you are enrolled in the HRA-Based Medical Plan, you cannot use your HRA dollars to pay for the additional 20% that becomes your responsibility.
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” section on page 2-3).

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.

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, diagnosing, or treating a sickness, an injury, mental illness, substance abuse, or their symptoms. To be a covered health service, the claims administrator must determine that the service is medically appropriate and:

- Necessary to meet the basic health needs of the participant.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply.
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations, or governmental agencies that are accepted by the utilization review organization or claims administrator.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the participant or his or her physician.
- In accordance with generally accepted standards of medical practice, as determined by the claims administrator. For these purposes, “generally accepted standards of medical practice” means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors, resulting in the conclusion that the service or supply is:
  - Safe and effective for treating or diagnosing the condition or sickness for which its use is proposed.
  - Safe with promising efficacy for treating a life-threatening sickness or condition in a clinically controlled research setting and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. (Life-threatening is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)
  - Not listed in any “Not covered” or “Exclusions” section.

Covered health services must be provided when all of the following conditions are met:

- The medical plan is in effect.
- Before the effective date of any of the individual termination conditions set forth in this chapter.
- When the person who receives services is enrolled in and meets all eligibility requirements specified in the health plan.
- The treating health care professional or facility is licensed or certified under state law to provide the health care services rendered and is acting within the scope of their licensure 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.
UnitedHealthcare administered account-based 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 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.

• When covered health services are received from out-of-network providers, the eligible expense is the lesser of the billed charge or 140% of the Medicare allowed amount. For hospital and facility charges and for other charges for which there is no Medicare allowed amount, the eligible expense is calculated according to the allowed amount for a given service or item, as determined by UnitedHealthcare. Your out-of-network provider may bill you for the amounts above the eligible expense; these amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.

When covered health services are received from an out-of-network provider as a result of an emergency or as arranged by UnitedHealthcare, eligible expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your annual deductible and any applicable coinsurance.

• Eligible expenses under the Shared Savings Program. Depending on the geographic area and the service you receive, you may have access to out-of-network providers who have agreed to discounted costs for services (in comparison to the provider’s typically billed charge for the particular service) through UnitedHealthcare’s Shared Savings Program. This discount is usually based on a schedule previously agreed to by the out-of-network provider. When this happens, you may experience lower out-of-pocket amounts. The plan’s annual deductible and coinsurance still apply to the reduced charge. Sometimes plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case, the out-of-network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens, you should call the number on your ID Card. Shared Savings Program providers are not in-network providers and are not credentialed by UnitedHealthcare.

• UnitedHealthcare’s reimbursement policy guidelines also apply. The reimbursement policy guidelines are developed, in UnitedHealthcare’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:
  – As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association
  – As reported by generally recognized professionals or publications
  – As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the claims administrator accepts

Anthem BCBS administered account-based medical plans and the Indemnity Medical Plan – Anthem BCBS

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

• HRA-Based Medical Plan, HSA-Based Medical Plan – Gold, and HSA-Based Medical Plan – Silver

When covered health services are received from in-network providers, the eligible expense is the negotiated amount of payment that the in-network providers have agreed to accept as full payment for a covered service based on their contract with Anthem BCBS. Your in-network provider may not bill you for amounts above the eligible expense for covered health services.

When you receive covered health services from out-of-network providers, the eligible expense is the lesser of the billed charge or 140% of the Medicare allowed amount. For hospital and facility charges and for other charges for which there is no Medicare allowed amount, the eligible expense is calculated according to the allowed amount for a given service or item, as determined by Anthem BCBS. Your out-of-network provider may bill you for the amounts above the eligible expense; these amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.

• Indemnity Medical Plan – Anthem BCBS

For team members who live in Puerto Rico, when covered health services are received from in-network providers, the eligible expense is the negotiated amount of payment that the in-network providers have agreed to accept as full payment for a covered service based on their contract with Anthem BCBS. Your in-network provider may not bill you for amounts above the eligible expense for covered health services.
When you receive covered health services from out-of-network providers, the eligible expense is the lesser of the billed charge or 140% of the Medicare allowed amount. For hospital and facility charges and for other charges for which there is no Medicare allowed amount, the eligible expense is calculated according to the allowed amount for a given service or item, as determined by Anthem BCBS. Your out-of-network provider may bill you for the amounts above the eligible expense; these amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.

- **Indemnity Medical Plan — Anthem BCBS**
  For team members who live in Guam or the Northern Mariana Islands (Saipan), when covered health services are received from in-network providers, the eligible expense is the negotiated amount of payment that the in-network providers have agreed to accept as full payment for a covered service based on their contract with Anthem BCBS. Your in-network provider may not bill you for amounts above the eligible expense for covered health services.

When you receive covered health services from providers, hospitals, or facilities that are out-of-network, the eligible expense is calculated according to the allowed amount for a given service or item, as determined by Anthem BCBS. Your out-of-network provider may bill you for the amounts above the eligible expense; these amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.

**HealthPartners administered account-based 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.
- When covered health services are received from out-of-network providers, eligible expenses are based on the Medicare fee schedule for professional services. HealthPartners reimburses 140% of the Medicare allowed amount. For hospital and facility charges and for other charges for which there is no Medicare allowed amount, the eligible expense is calculated according to the allowed amount for a given service or item, as determined by HealthPartners. Your out-of-network provider may bill you for the amounts above the eligible expense; these amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.

**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 2-49 for more information.)

These 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.

Coinsurance is based on eligible expenses for covered health services. In addition to the 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. The annual deductible is referred to as “deductible” in the cost-sharing tables that follow, beginning on page 2-52. 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 for services received from an out-of-network provider. For more information about the annual deductible, see the “Important terms” section starting on page 2-8.

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 licensure or certification. For more information on providers, see the “Providers and provider networks” section starting on page 2-6.
## Acupuncture

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
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<tbody>
<tr>
<td><strong>HRA-Based Medical Plan</strong></td>
<td><strong>In-network providers</strong></td>
</tr>
<tr>
<td></td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible, limited to 26 visits per plan year, in-network and out-of-network services combined.</td>
</tr>
<tr>
<td></td>
<td>* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.</td>
</tr>
</tbody>
</table>

| **HSA-Based Medical Plan**                | **In-network providers**  | **Out-of-network providers**  | **Out of Area* coverage** |
| **– Gold**                                | You pay 20% of eligible covered expenses after you satisfy the deductible, limited to 26 visits per plan year, in-network and out-of-network services combined. | You pay 40% of eligible covered expenses after you satisfy the deductible, limited to 26 visits per plan year, in-network and out-of-network services combined. | You pay 20% of eligible covered expenses after you satisfy the deductible, limited to 26 visits per plan year, in-network and out-of-network services combined. |
| **– Silver**                              | **In-network providers**  | **Out-of-network providers**  | **Out of Area* coverage** |
|                                           |                       |                                      |                                      |
| **Indemnity Medical Plan — Anthem**       | You pay 20% of eligible covered expenses after you satisfy the deductible, limited to 26 visits per plan year, in-network and out-of-network services combined. |                        |                                      |

### The medical plans cover

The medical plans cover acupuncture services received from a licensed or certified physician, chiropractor, or acupuncturist acting within the scope of that license or certification, limited to 26 visits per plan year, in-network and out-of-network services combined.

Covered health services include services needed for pain therapy. Covered health services also include treatment for nausea as a result of the following:

- Chemotherapy
- Pregnancy
- Postoperative procedures

### Not covered

All other acupuncture services.

Also, refer to the “Exclusions” section starting on page 2-114.

### Notes

#### UnitedHealthcare and Anthem BCBS:
If a service is performed by a chiropractor, it will be applied to the 26-visit chiropractic benefit limit.

If you move during the plan year, resulting in a change in your claims administrator, the 26-visit limit per plan year will start over under the new claims administrator.

#### HealthPartners:
Pre-service authorization is required before receiving acupuncture services for all visits after 12 in a plan year.
## Ambulance

<table>
<thead>
<tr>
<th>Plan</th>
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<th>In-network providers</th>
<th>Out-of-network providers</th>
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</tr>
<tr>
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<td>You pay 20% of eligible covered expenses after you satisfy the in-network deductible.</td>
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<td></td>
</tr>
<tr>
<td>HSA-Based Medical Plan – Silver</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
<td>You pay 20% of eligible covered expenses after you satisfy the in-network deductible.</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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</table>

*These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

## The medical plans cover

The medical plans cover the following types of professional ambulance services:

- Ambulance service from the place of emergency departure to the nearest local hospital, required for stabilization and initiation of treatment as provided under the direction of a physician in an emergency situation.

- Air ambulance to the nearest facility qualified to give the required treatment, as determined by the claims administrator, when ground ambulance transportation is not medically appropriate because of the distance involved or because the covered patient has an unstable condition requiring medical supervision and rapid transport. This would include transportation, if needed in a foreign country, to transport to the nearest facility qualified to treat the patient as determined by the claims administrator.

- Ambulance transport to a hospital at the next level of acute care services, for example, a skilled nursing facility or rehabilitation facility (does not include transport to custodial care or facility, or transport to a residence).

- Ambulance transport from a skilled nursing facility or rehabilitation facility to another facility or hospital for tests or diagnosis when such tests or diagnostics cannot be rendered at the initial facility.

## Not covered

- Nonemergency services, except as noted on this page.

- Transportation services that are not necessary for basic or advanced life support.

- Transportation services that are mainly for your convenience.

Also, refer to the “Exclusions” section starting on page 2-114.

## Notes

**UnitedHealthcare:**

Nonemergent ambulance services are subject to pre-service authorization (see the “Pre-service authorization requirements” section starting on page 2-44 for more information).
## Autism coverage

<table>
<thead>
<tr>
<th>Plan</th>
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<tr>
<td><strong>In-network providers</strong></td>
<td><strong>Out-of-network providers</strong></td>
</tr>
<tr>
<td><strong>HRA-Based Medical Plan</strong></td>
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</tr>
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<td><strong>HSA-Based Medical Plan</strong></td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
</tr>
<tr>
<td><strong>Indemnity Medical Plan — Anthem</strong></td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
</tr>
</tbody>
</table>

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

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## The medical plans cover

The medical plans cover Applied Behavioral Analysis (ABA) Intensive Behavioral Therapy (IBT) for enrolled participants and dependents diagnosed with autism, and autism spectrum disorders. ABA IBT is behavioral therapy focused on primarily building skills and capabilities in communication, social interaction, and learning services. **It is strongly recommended that you call the applicable claims administrator before receiving services** to ensure that the services you seek are covered under the plan. In addition, you can get information about in-network providers available in your area. Please note that inpatient hospital treatment or other inpatient medical facility admissions, such as residential treatment or structured outpatient care, which is considered a form of inpatient care, require pre-service authorization (see the “Pre-service authorization requirements” section starting on page 2-44 for more information).

Generally, covered services include:

- Diagnostic evaluations and assessment
- Treatment planning
- Referral services
- Medical management
- Inpatient or 24-hour supervisory care, or both
- Partial hospitalization, day treatment, or both
- Intensive outpatient treatment
- Services at a Residential Treatment Facility
- Individual, family, therapeutic group, and provider-based case management services
- Psychotherapy, consultation, and training session for parents and paraprofessional, and resource support to family
- Crisis intervention
- Transitional care
Not covered

- Tuition for school-based programs for autism and autism spectrum disorders
- Any related supplies or equipment associated with the treatment of autism, other than ABA IBT as previously noted, even if the supplies or equipment are recommended or prescribed by a physician

Also, refer to the “Exclusions” section starting on page 2-114.

Notes
For services coded as an office visit (excluding ABA IBT services), refer to the “Office visit — outpatient mental health and substance abuse” section starting on page 2-92.
# Bariatric services

<table>
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## The medical plans cover
Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover gastric bypass or lap band surgery if specific criteria are met. For the HRA-Based Medical Plan and the HSA-Based Medical Plan, services must be received at a designated facility. The medical policy or coverage criteria of the claims administrator are used to determine eligibility for coverage. Contact your claims administrator before receiving services for specific criteria and pre-service authorization.

## Not covered
- All other weight loss-related services, supplies, or treatments, including weight loss programs, health clubs, or spas
- Experimental, investigational, or unproven services
- Excess skin removal after successful weight loss, regardless of need
- 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
- Repeat weight loss surgery, meaning a second or subsequent procedure performed regardless of type of weight loss surgery performed and regardless of coverage at the time of the previous procedure

Also, refer to the “Exclusions” section starting on page 2-114.

## Notes
**UnitedHealthcare:**
Enrollment for the bariatric services program must be initiated with Bariatric Resource Services before receiving services. Covered participants seeking coverage for bariatric surgery should call Bariatric Resource Services at 1-888-936-7246 to determine if they meet the criteria to enroll in the program. This is a comprehensive program that requires patients to meet
established UnitedHealthcare Bariatric Surgery medical policy and also requires presurgery psychological evaluation. In order for surgery to be covered, compliance with all components of the bariatric services program is required.

After the member is enrolled, the Optum Care Advocate from the Bariatric Outreach Unit will coordinate ongoing psychological care with United Behavioral Health network providers and a designated facility. The mental health benefits provisions apply to any psychological care received. See the “Office visit — outpatient mental health and substance abuse” section starting on page 2-92 for coverage details.

All bariatric services, including nutritional counseling, must be received at a designated Center of Excellence facility to be covered. Any services received outside of a designated facility are not covered and no benefits will be paid. A designated Center of Excellence facility may or may not be located within your geographic area. Depending on the location of the designated facility, you may be eligible for reimbursement of a portion of transportation and lodging. The services described in the “Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery” section on page 2-111 are covered health services only in connection with the program’s morbid obesity bariatric services received at a designated facility after enrollment in the program.

A designated facility has entered into an agreement with UnitedHealthcare, or with an organization contracting on behalf of the medical plan, to provide covered health services for the treatment of specified diseases or conditions. A designated facility may or may not be located within your geographic area. To be considered a designated facility, the facility must meet certain standards of excellence and have a proven track record of treating specified conditions as determined by UnitedHealthcare. Note that a facility is not necessarily considered a designated facility just because it’s an in-network provider.

**Anthem BCBS:**

You must receive services from a Blue Distinction Center for Bariatric Surgery (a designated facility) in order for services to be covered. Note that a facility is not necessarily considered a designated facility just because it’s an in-network provider.

For a list of Blue Distinction Centers for Bariatric Surgery, call Member Service or visit Anthem BCBS’s website. Refer to the “Contacts” section on page 2-3 for information.

If you live more than 50 miles from a Blue Distinction Center for Bariatric Surgery, please refer to the “Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery” section on page 2-111.

Blue Distinction Centers for Bariatric Surgery are designated facilities within the participating Blue Cross Blue Shield organization’s service areas that have been selected after a rigorous evaluation of clinical data that provided insight into the facility’s structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent, objective assessment of specialty care capabilities. Blue Distinction Centers for Bariatric Surgery meet stringent quality criteria, as established by expert physician panels, surgeons, behaviorists, and nutritionists. The national Blue Distinction Centers for Bariatric Surgery have been developed in conjunction with other Blue Cross Blue Shield organizations and the Blue Cross Blue Shield Association.

**Exception:** Members enrolled in the following medical plan options administered by Anthem BCBS are not required to receive services from a Blue Distinction Center and participating provider:

- HRA-Based Medical Plan Out of Area coverage only
- HSA-Based Medical Plan – Gold Out of Area coverage only
- HSA-Based Medical Plan – Silver Out of Area coverage only
- Indemnity Medical Plan – Anthem BCBS

**HealthPartners:**

Members must use a HealthPartners designated network weight loss provider, and pre-service authorization is required before receiving services. Services are not covered if they are received from providers who are not HealthPartners designated network weight loss providers. Note that a facility is not necessarily considered a designated facility just because it’s an in-network provider.
# Chiropractic care and spinal manipulation

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<td><strong>Out-of-network providers</strong></td>
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<td><strong>Out-of-network providers</strong></td>
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<tr>
<td>Mariana Islands (Saipan))</td>
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</table>

**The medical plans cover**

The medical plans cover spinal treatment (including chiropractic and osteopathic manipulative therapy) when provided by a spinal treatment provider in the provider’s office. Benefits include diagnosis and related services and are limited to one visit and treatment per day, 26 visits per plan year, in-network and out-of-network services combined. The medical plans also cover massage therapy that is performed in conjunction with other treatment or modalities by a provider licensed to render this service and is part of a prescribed treatment plan and not billed separately.

**Not covered**

- Massage therapy, except as noted on this page
- Therapy, service, or supply, including but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition that ceases to be therapeutic treatment, such as maintaining a level of functioning or preventing a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness such as asthma or allergies
- Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, or social disadvantages)
• Services for or related to educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting) and all related charges

• Services for or related to forms of nonmedical self-care or self-help training, including but not limited to health club memberships, aerobic conditioning, therapeutic exercises, and all related charges

• Services for or related to work-hardening programs or vocational rehabilitation and all related charges for these programs

• Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time

Also, refer to the “Exclusions” section starting on page 2-114.

Notes
If you move during the plan year, resulting in a change in your claims administrator, the 26-visit limit per plan year will start over under the new claims administrator.
### Convenience care and telemedicine

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<tr>
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### The medical plans cover

The medical plans cover care received at a convenience clinic, also known as a retail health clinic. Convenience clinics typically treat minor health issues such as sore throats and ear and sinus infections. You will be directed to a clinic or hospital if you cannot be treated at a convenience clinic. The medical plans also cover charges for telephone, email, and internet consultation, as well as telemedicine.

**Note:** A convenience clinic is not an urgent care center. For information on benefits related to urgent care, see the “Emergency and urgent care” section on page 2-66.

### Not covered

Refer to the “Exclusions” section starting on page 2-114.
## Dental care

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The 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 medical plans also cover dental x-rays, supplies, and appliances, and all associated expenses, including hospitalizations and anesthesia necessary to:

- Prepare for transplant
- Initiate immunosuppressives
- Diagnose cancer
- Directly treat current instance of cancer
Accidental dental services
Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover treatment received from a physician or dentist for an accidental injury to sound, natural teeth when performed within 12 months from the date of injury. Coverage is for damage caused by external trauma to face and mouth only.

Note: All eligible accidental dental services are covered at the in-network benefit level.

Treatment of cleft lip and cleft palate
Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover treatment of cleft lip and palate for a dependent child under age 18.

Orthognathic surgery
Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the plans cover orthognathic surgery that meets the claims administrator’s medical policy criteria.

Oral surgery
Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover certain outpatient oral surgery performed in the oral surgeon’s office. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, nondental cysts, fracture of the jaws, and trauma of the mouth and jaws.

Temporomandibular joint disorder (TMJ)
Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover the following:

- Services for nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, which include removable appliances for TMJ. Covered services do not include fixed or removable appliances that involve movement or repositioning of the teeth or operative restoration of the teeth or prosthetics.

- Orthognathic surgery is covered for the treatment of TMJ and craniomandibular disorder, as determined by the medical policy criteria of the claims administrator.

Not covered
The following dental care services are not covered regardless of whether they are medical or dental in nature:

- Accident-related dental services not performed within 12 months from the date of injury.
- Any dental procedure or treatment not listed as covered within this SPD.
- Dental services to treat an injury or cracked or broken teeth that result from biting or chewing.
- Dentures, regardless of the cause or the condition, and any associated services or charges, including bone grafts.
- Dental implants, regardless of the cause or the condition, and any associated services or charges, including bone grafts, and all associated expenses.
- Dental braces or orthodontia services and all associated expenses.
- Dental x-rays, supplies, and appliances, and all associated expenses, including hospitalizations and anesthesia, except as previously noted.
- Oral appliances except as needed for medical conditions affecting temporomandibular joint disorder (TMJ). See the “Temporomandibular joint disorder (TMJ)” section on this page for more information.
- Oral surgery and all associated expenses, including hospitalizations and anesthesia, except as previously noted.
- Procedures associated with the fitting of dentures (including osteotomies for this purpose).
- Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums, and all associated expenses, including hospitalizations and anesthesia, except as previously noted.
- Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly, and all associated expenses, including hospitalizations and anesthesia, except as previously noted.

Also, refer to the “Exclusions” section starting on page 2-114.
## Durable medical equipment, supplies, and prosthetics

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The medical plans cover durable medical equipment and supplies that meet each of the following criteria:

- Ordered, prescribed, or provided by a physician for outpatient use for the patient’s diagnosed condition
- Used for medical purposes
- Equipment, appliances, or devices that are not consumable or disposable
- Not of use to a person in the absence of a disease or disability
- For orthotic appliances and devices, that the items must be custom manufactured or custom fitted to the patient for diagnosed condition

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

Benefits are provided for the replacement of durable medical equipment when it can no longer be repaired to have it function at its original specifications. This will be not more often than once every three years unless there is a change in a covered person’s medical condition that requires repairs or replacement sooner (for example, due to growth of a dependent child).

The medical plans also cover a single purchase, including repairs, of a prosthetic device that replaces a limb or body part, including artificial limbs and artificial eyes. The medical plans also cover breast prosthesis as required by the Women’s Health and Cancer Rights Act of 1998.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device as determined by the applicable claims administrator. The prosthetic device must be ordered or provided by or under the direction of a physician.

Benefits are provided for the replacement of each type of prosthetic device when it can no longer be repaired to have it function at its original specifications. This will be not more often than every three years.
Covered durable medical equipment includes the following when the claims administrator's medical criteria are met:

- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces
- Braces to treat curvature of the spine
- Compression stockings when used for care related to the diagnosis of lymphedema
- Cranial bands and helmets for children up to 18 months old
- Delivery pumps for tube feeding
- Insulin pumps, pump supplies, and glucose monitors
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions
- Oxygen concentrator units and equipment rental to administer oxygen
- Shoe or foot orthotics
- Standard hospital bed
- Wheelchair

Covered supplies include:

- Burn garments
- Ostomy supplies (pouches, face plates, and belts; irrigation sleeves, bags, and catheters; and skin barriers)
- Disposable urinary catheters
- Disposable wound vac
- Surgical dressings, casts, splints, trusses, crutches, and noncorrective contact lens bandages

Note: For women's preventive health care services including contraceptive devices (including intrauterine devices, diaphragms, and implants) and breast feeding equipment, see the “Women’s preventive health care services” section starting on page 2-112.

**Not covered**

Items that are not eligible for coverage include, but are not limited to:

- Cranial bands, banding, remolding, and helmets for individuals 18 months or older
- Dental braces
- Items that can be obtained without a prescription or physician's order
- Devices used specifically as safety items or to affect performance in sports-related activities
- Prescribed or nonprescribed medical supplies and disposable supplies, including elastic stockings, ace bandages, gauze, and dressings, except as noted above
- Tubings, nasal cannulas, connectors, and masks, except when used with durable medical equipment
- Appliances for snoring, including sleep apnea
- Oral or dental prosthesis, except as previously noted within the “Dental care” section or as otherwise deemed medically necessary by the claims administrator
- Replacement or repair of any covered items, if the items are:
  - Damaged or destroyed by misuse, abuse, or carelessness
  - Lost
  - Stolen
- Duplicate or similar items
- Labor and related charges for repair of any covered items that are more than the cost of replacement by an approved vendor
- Sales tax, mailing and delivery, and service call charges
- The cost of an extended warranty or a service contract
- Items that are primarily educational in nature or for hygiene, vocation, comfort, convenience, or recreation
- Communication aids or devices:
  - Equipment to create, replace, or augment communication abilities, including but not limited to speech processors, receivers, communication boards, or computer or electronic-assisted communication, except as specifically described in this SPD
- Diets for weight control or treatment of obesity (including liquid diets or food)
- Food, food substitutes, or food supplements (such as diabetic, low-fat, low-cholesterol, or infant formula) unless specifically noted in this SPD
- Megavitamin and nutrition-based therapy
- Household equipment that primarily has customary uses other than medical
- Household fixtures, including but not limited to escalators or elevators, ramps, swimming pools, whirlpools, and saunas
- Modifications to the structure of the home, including but not limited to wiring, plumbing, or charges for installation of equipment
• Vehicle, car, or van modifications, including but not limited to hand brakes, hydraulic lifts, and car carriers

• Rental equipment while the covered person’s owned equipment is being repaired, beyond one-month rental of equipment

• Other equipment and supplies, including but not limited to assistive devices that the claims administrator determines are not eligible for coverage

• Hearing aids or devices, whether internal, external, or implantable, and related fitting or adjustment, except as specified in this SPD; see the “Hearing aids” section on page 2-71 for more information

• Eyeglasses, contact lenses, or other optical devices or professional services 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 2-127 for information on diabetic supplies

• Scalp hair prostheses (wigs)

• 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
  – Car seats
  – 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

Also, refer to the “Exclusions” section starting on page 2-114.

Notes

UnitedHealthcare:
Pre-service authorization is required before obtaining any single item of durable medical equipment that costs $1,000 or more (either purchase price or cumulative rental of a single item).

UnitedHealthcare covers a single unit of durable medical equipment (for example, one insulin pump), and provides repair for that unit. Benefits are provided for replacement of a type of durable medical equipment once every three years, unless there is a change in the covered person’s medical condition that requires repair or replacement sooner (for example, due to growth of a dependent child).

Anthem BCBS:
Pre-service authorization is required for durable medical equipment that costs $1,000 or more (either purchase price or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost $1,000 or more (either purchase price or cumulative rental of a single item).

HealthPartners:
Durable medical equipment and supplies must be obtained from, or repaired by, approved vendors. Pre-service authorization is required for durable medical equipment or prosthetics that cost $1,000 or more (either purchase price or cumulative rental of a single item).
## Emergency and urgent care

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HRA-Based Medical Plan</strong></td>
<td><strong>In-network providers</strong></td>
</tr>
<tr>
<td><strong>HSA-Based Medical Plan</strong></td>
<td><strong>In-network providers</strong></td>
</tr>
<tr>
<td><strong>Indemnity Medical Plan — Anthem</strong></td>
<td><em><em>Out of Area</em> coverage</em>*</td>
</tr>
<tr>
<td>(only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan))</td>
<td><em><em>Out of Area</em> coverage</em>*</td>
</tr>
</tbody>
</table>

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

### The medical plans cover

The medical plans cover emergency care services for accidental injury and other medical emergencies treated in an emergency room if, in the judgment of an reasonable person, immediate care and treatment are required, generally within 24 hours of onset, to avoid jeopardy to life or health.

The medical plans also cover services received at an urgent care center to treat urgent health care needs.

For ambulance services, see the “Ambulance” section on page 2-53.

### Not covered

- 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, refer to the “Exclusions” section starting on page 2-114.
### Extended skilled nursing care

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HRA-Based Medical Plan</strong></td>
<td><strong>In-network providers</strong></td>
</tr>
<tr>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.</td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.</td>
</tr>
</tbody>
</table>

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

<table>
<thead>
<tr>
<th><strong>HSA-Based Medical Plan</strong></th>
<th><strong>In-network providers</strong></th>
<th><strong>Out-of-network providers</strong></th>
<th><em><em>Out of Area</em> coverage</em>*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gold</strong></td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.</td>
<td>You pay 40% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.</td>
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<table>
<thead>
<tr>
<th><strong>Indemnity Medical Plan — Anthem</strong></th>
<th><strong>What you pay</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan))</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.</td>
</tr>
</tbody>
</table>

### The medical plans cover

With pre-service authorization before receiving services, the medical plans cover extended skilled nursing care. Extended skilled nursing care is defined as the use of skilled nursing services delivered or supervised by a registered nurse (RN) or licensed practical nurse (LPN) to obtain the specified medical outcome and provide for the safety of the patient. To be covered:

- An attending physician must order extended skilled nursing care.
- Certification of the RN or LPN providing the care is required.
- The claims administrator, in its sole discretion, must determine that the extended skilled nursing care is a covered health service.

- The covered person and the provider must obtain pre-service authorization from the claims administrator (see the “Pre-service authorization requirements” section starting on page 2-44).

Benefits are limited to 100 visits per plan year combined with home health care (the 100-visit maximum is for in-network and out-of-network services combined). Each 24-hour visit (or shifts of up to 24-hour visits) equals one visit and counts toward the 100 combined visits. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the 100-visit limitation (combined with home health care).
Services provided under the following circumstances will be considered extended skilled nursing services:

- Transition of the covered person from an inpatient setting to home.
- The covered person becomes acutely ill and the additional skilled nursing care may prevent a hospital admission.
- The covered person meets the clinical criteria for confinement in a skilled nursing facility, but a skilled nursing facility bed is not available. In this situation, additional skilled nursing may be provided until a skilled nursing facility bed becomes available.
- The covered person is on a ventilator or is dependent on continuous positive airway pressure due to respiratory insufficiency at home and whose condition shows frequent changes. Once the person’s condition does not show the need for frequent changes, the extended skilled nursing is not needed.

Note: For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home, refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information and pre-service authorization requirements and instructions.

Not covered

- Nursing care that does not require the education, training, and technical skills of an RN or LPN.
- Nursing care provided for skilled observation.
- Nursing care provided while the covered person is an inpatient in a hospital or health care facility.
- Nursing care to administer routine maintenance medications or oral medications, except where law requires an RN or LPN to administer medicines.
- Custodial care for daily life activities, including but not limited to:
  - Transportation
  - Meal preparation
  - Vital sign charting
  - Companionship activities
  - Bathing
  - Feeding
  - Personal grooming
  - Dressing
  - Toileting
  - Getting in or out of bed or a chair
- Services that can be safely and effectively performed by a nonmedical person or self-administered without the direct supervision of a licensed nurse. The unavailability of a person to provide an unskilled service does not allow for coverage for a nurse to provide unskilled services.
- Private-duty nursing.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by CVS Caremark. Refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information.

Also, refer to the “Exclusions” section starting on page 2-114.

Notes

If you move during the plan year, resulting in a change in your claims administrator, the 100-visit limit (combined with home health care) per plan year will start over under the new claims administrator.
## Gender reassignment

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
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</thead>
</table>
| **HRA-Based Medical Plan**| In-network providers
Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.|
|                          | Out-of-network providers
Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses after you satisfy the deductible.|
|                          | Out of Area* coverage
Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.|

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
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</thead>
</table>
| **HSA-Based Medical Plan**| In-network providers
You pay 20% of eligible covered expenses after you satisfy the deductible.|
| – Gold                    | Out-of-network providers
You pay 40% of eligible covered expenses after you satisfy the deductible.|
| – Silver                  | Out of Area* coverage
You pay 20% of eligible covered expenses after you satisfy the deductible.|

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

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<th>Plan</th>
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</thead>
<tbody>
<tr>
<td><strong>Indemnity Medical Plan — Anthem</strong> (only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan))</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
</tr>
</tbody>
</table>

### The medical plans cover

For gender reassignment surgery benefits, the criteria for diagnosis and treatment are based on the guidelines set forth by the World Professional Association for Transgender Health (WPATH). Note that not all WPATH recommended services are covered under this Plan. Gender reassignment surgery benefits are limited to one reassignment per covered person per lifetime.

Inpatient hospital services require pre-service authorization (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). **However, it is strongly recommended that you call the applicable claims administrator before receiving any related services** to ensure that the services you seek are covered under the plan. In addition, you can get information about in-network providers available in your area. See the “Pre-service authorization requirements” section starting on page 2-44 for the contact information.

### Generally, covered expenses include:

- Outpatient office visits (see the “Office visit — primary care physician (PCP)” section on page 2-89 and the “Office visit — outpatient mental health and substance abuse” section on page 2-92 for more information).
- Pre- and postsurgical hormone therapy covered under the pharmacy benefit (refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information and any pre-service authorization instructions).
- Facial feminization surgery (male to female), including but not limited to facial bone reduction, face “lift,” facial hair removal, and certain facial plastic procedures.
- Voice therapy.
- Hair removal (male to female) for skin grafting related to genital reconstruction.
• Genital surgery and surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty) when the treatment plan conforms to the most recent edition of the World Professional Association for Transgender Health: Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Inpatient hospital services or treatment require pre-service authorization (see the “Pre-service authorization requirements” section starting on page 2-44 for more information).

Not covered
• Cosmetic surgery or other services performed solely for beautification or to improve appearance, such as breast augmentation or reduction and electrolysis; this exclusion does not apply to mastectomy and mastectomy scar revision for a female-to-male transition.
• Charges for services or supplies that are not based on the guidelines set forth by the World Professional Association for Transgender Health (WPATH).
• Cryopreservation of fertilized embryos.
• Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
• Sperm preservation in advance of hormone treatment or gender surgery.
• Voice modification surgery.
Also, refer to the “Exclusions” section starting on page 2-114.
## Hearing aids

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<tr>
<th>Plan</th>
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<tbody>
<tr>
<td></td>
<td><strong>In-network providers</strong></td>
</tr>
<tr>
<td>HRA-Based Medical Plan</td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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\(^*\) These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

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</thead>
<tbody>
<tr>
<td></td>
<td><strong>In-network providers</strong></td>
</tr>
<tr>
<td>HSA-Based Medical Plan – Gold – Silver</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
</tr>
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</table>

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<tr>
<td>Indemnity Medical Plan — Anthem (only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan))</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
</tr>
</tbody>
</table>

### The medical plans cover

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

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver. Benefits are available for a hearing aid that is prescribed by a physician or appropriate provider or clinician as determined by the claims administrator. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

The plans also cover external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the medical plan. Cochlear implantation can either be an inpatient or outpatient procedure. Check with your claims administrator for pre-service authorization requirements.

### Not covered

- Bone-anchored hearing aids, except as specifically described in the claims administrator’s medical policy
- Hearing aid batteries, including but not limited to cochlear implant batteries

Also, refer to the “Exclusions” section starting on page 2-114.
## Home health care

<table>
<thead>
<tr>
<th>Plan</th>
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<td><strong>HRA-Based Medical Plan</strong></td>
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<td></td>
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<td>expenses, then you pay 20% of eligible covered</td>
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<td>expenses after you satisfy the deductible. Benefits</td>
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<td>are limited to 100 visits per plan year combined with</td>
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<td>extended skilled nursing care, in-network and out-of-</td>
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<td></td>
<td>network services combined.</td>
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</table>
|                               |                                                        | nursing care, in-network and out-of-
|                               |                                                        | network services combined. |

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

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<td></td>
<td>You pay 20% of eligible covered expenses after you</td>
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<td>satisfy the deductible. Benefits are limited to</td>
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<td></td>
<td>100 visits per plan year combined with extended</td>
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<td></td>
<td>extended skilled nursing care, in-network and out-of-</td>
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<td></td>
<td>network services combined.</td>
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</tbody>
</table>
|                               |                                                        | skilled nursing care, in- | skilled nursing care, in-
|                               |                                                        | network and out-of-network| network and out-of-network |
|                               |                                                        | services combined.        | services combined.        |

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<td>**Indemnity Medical Plan —</td>
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<td>satisfy the deductible. Benefits are limited to</td>
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<tr>
<td>Puerto Rico, Guan, and the</td>
<td>100 visits per plan year combined with extended</td>
</tr>
<tr>
<td>Northern Mariana Islands</td>
<td>skilled nursing care, in-network and out-of-network</td>
</tr>
<tr>
<td>(Saipan))</td>
<td>services combined.</td>
</tr>
</tbody>
</table>

The medical plans pay for covered health services for treatment of a disease or injury in the patient’s home instead of a hospital or skilled nursing facility. The charge must be made by a home health care agency. Home health care must be prescribed by a physician and supervised by a registered nurse (RN) in the patient’s home, and provided by a home health aide or licensed practical nurse (LPN) in the patient’s home. Benefits are available only when the home health agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. Skilled home health care is skilled...

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**The medical plans cover**

Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover certain home health care services limited to 100 visits per plan year by a home health care professional (the 100-visit maximum is for combined in-network and out-of-network services) combined with extended skilled nursing care. One visit is equal to four consecutive hours in a 24-hour period.
nursing, teaching, and rehabilitation services provided by licensed technical or professional medical personnel to obtain a medical outcome and provide for the patient’s safety.

The medical plans cover the following home health care expenses up to the 100-visit limit, combined with extended skilled nursing care, in-network and out-of-network services combined:

- Part-time or occasional care by a licensed nurse
- Intermittent home health aide services
- Services of a medical social worker
- Physical, occupational, speech, and inhalation therapy
- Eligible medical supplies prescribed by a physician
- Services of a nutritionist

Note: For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home, refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information and pre-service authorization requirements and instructions.

Not covered

- Services provided by a home health agency when a primary caregiver could provide those same services in the home. Home health services are not provided as a substitute for a primary caregiver in the home or as a relief (respite) for a primary caregiver in the home.
- Services provided by a primary caregiver in the home.
- Custodial or nonskilled care, maintenance care, or home health care delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair. Custodial or maintenance care includes but is not limited to help getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs. This type of care is primarily required to meet the patient’s personal needs or maintain a level of function, as opposed to improving that function to allow for a more independent existence. The care does not require continued administration by trained medical personnel to be delivered safely and effectively.
- Services of a nonmedical nature.
- Services that can be safely and effectively performed by a nonmedical person or self-administered without the direct supervision of a licensed nurse. The unavailability of a person to provide an unskilled service does not allow for coverage for a home health care provider to provide unskilled services.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by CVS Caremark. Refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information.
- Services provided by a family member or a person living in your home.
- Private-duty nursing (see the “Extended skilled nursing care” section starting on page 2-67 for more information).

Also, refer to the “Exclusions” section starting on page 2-114.

Notes

If you move during the plan year, resulting in a change in your claims administrator, the 100-visit limit (combined with extended skilled nursing care) per plan year will start over under the new claims administrator.
## Homeopathic services

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
<th>In-network providers</th>
<th>Out-of-network providers</th>
<th>Out of Area* coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HRA-Based Medical Plan</strong></td>
<td></td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible, limited to 20 visits per plan year, in-network and out-of-network services combined.</td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses after you satisfy the deductible, limited to 20 visits per plan year, in-network and out-of-network services combined.</td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible, limited to 20 visits per plan year, in-network and out-of-network services combined.</td>
</tr>
<tr>
<td><strong>HSA-Based Medical Plan</strong></td>
<td></td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible, limited to 20 visits per plan year, in-network and out-of-network services combined.</td>
<td>You pay 40% of eligible covered expenses after you satisfy the deductible, limited to 20 visits per plan year, in-network and out-of-network services combined.</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible, limited to 20 visits per plan year, in-network and out-of-network services combined.</td>
</tr>
<tr>
<td><strong>Indemnity Medical Plan — Anthem</strong></td>
<td></td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible, limited to 20 visits per plan year, in-network and out-of-network services combined.</td>
<td></td>
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</tr>
</tbody>
</table>

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

### The medical plans cover

The medical plans cover homeopathic office visits with a state-licensed homeopathic provider up to a maximum of 20 visits per plan year (the 20-visit maximum is for in-network and out-of-network services combined).

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

### Not covered

- Charges from a provider not licensed in homeopathy
- Charges in addition to the office visit charge, including but not limited to charges for equipment, supplies, or supplements
- Charges for or related to naturopathic treatment, or services received from a naturopathic provider

Also, refer to the “Exclusions” section starting on page 2-114.

### Notes

If you move during the plan year, resulting in a change in your claims administrator, the 20-visit limit per plan year will start over under the new claims administrator.
## Hospice care

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
<th>Out-of-network providers</th>
<th>Out of Area* coverage</th>
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<tbody>
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<td>HRA-Based Medical Plan</td>
<td><strong>In-network providers</strong> Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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<tr>
<td></td>
<td><strong>Out-of-network providers</strong></td>
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<td></td>
<td><em><em>Out of Area</em> coverage</em>*</td>
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<td><strong>Out-of-network providers</strong></td>
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<td>– Silver</td>
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<td>Indemnity Medical Plan — Anthem (only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan))</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
<td></td>
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</tr>
</tbody>
</table>

### The medical plans cover

Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover hospice care that is prescribed by a physician. Hospice care is an integrated program that provides supportive care to terminally ill individuals and their families. This care may be provided instead of a hospital confinement when a covered individual is terminally ill and has less than six months to live. Benefits are available when hospice care is received from a licensed hospice agency for the following services:

- Symptom management
- Inpatient care
- In-home health care services, including nursing care, use of medical equipment, wheelchair and bed rental, and home health aide care
- Physician services
- Respite care (hospice settings only) limited to five consecutive days per episode up to a maximum of 20 days in a 12-month period (rolling 12 months), combined in- and out-of-network services
- Emotional support services
- Bereavement counseling for covered family members while the covered person is receiving hospice care

### Not covered

- Room and board expenses in a nonapproved residential hospice facility
- Financial or legal counseling services
- Housekeeping or meal services in the patient’s home
- Custodial care related to hospice services, whether provided in the home or in a nursing home
- Any service not specifically described as a covered service under hospice services
- Any services provided by a member of the patient’s family or resident in the covered person’s home

Also, refer to the “Exclusions” section starting on page 2-114.
**Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)**

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<tr>
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<td>In-network providers^1</td>
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<td>HRA-Based Medical Plan</td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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<td>If you need eligible spine (back) and joint (knees and hips) procedures, refer to the “Orthopedic treatment decision support” section on page 2-43.</td>
</tr>
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1. If you need eligible spine (back) and joint (knees and hips) procedures, refer to the “Orthopedic treatment decision support” section on page 2-43. There is no out-of-network coverage for these services.
2. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

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**The medical plans cover**

Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover the following types of inpatient hospital services:

- Anesthesia
- Blood and blood derivatives (unless donated or replaced), including charges for presurgical self-blood donations
- Care received for medical stabilization in connection with inpatient services
- Drugs and anesthetics and their administration
- General nursing care
- Intensive care and intensive cardiac care facilities
- Laboratory and diagnostic imaging services
- Miscellaneous medically appropriate hospital services and supplies, including operating room, except as noted under the “Not covered” section on the following page
- Newborn nursery facilities
- Other diagnostic or treatment-related hospital services
- Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level
- Physician and other professional medical and surgical services during an inpatient hospital stay
- Prescription drugs or other medications administered during treatment
- Residential treatment or structured outpatient care (which are considered forms of inpatient care)
- Semiprivate room and board
- Use of operating rooms
Christian Science services when provided by a Christian Science practitioner or Christian Science nurse for charges while confined for healing purposes in a Christian Science sanatorium for a condition that would require a person of another faith to enter an acute care hospital

**Not covered**
- Admission for diagnostic tests that can be performed on an outpatient basis
- Comfort or convenience items such as television, telephone, beauty or barber service, or guest service
- Inpatient care that occurs after your coverage terminates, except where a claims administrator’s agreement with the provider covers the entire inpatient facility stay
- Late charges for less than a full day of hospital confinement, if for patient convenience
- Private-duty nursing
- Private room charges when facility has a semiprivate room available
- Telephone toll billings for Christian Science services

Also, refer to the “**Exclusions**” section starting on page 2-114.

**Notes**

**UnitedHealthcare:**
Physician and surgeon services received during the inpatient hospital stay:
- If you use an in-network or out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.
- Where assistant surgeon services are appropriate, UnitedHealthcare will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.
- Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

**Orthopedic Treatment Decision Support**
If you complete Orthopedic Treatment Decision Support (“Treatment Decision Support” or “TDS”) and use a designated facility for eligible spine (back) and joint (knees and hips) inpatient surgery, the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an in-network provider that is not a designated facility or you have not completed TDS (even if you use an in-network provider or a designated facility), the plan pays 80% of eligible expenses after you satisfy the annual deductible. No coverage for services received from out-of-network providers.

Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant’s spine (back) and joint (knees and hips) inpatient surgery.

**Anthem BCBS:**
When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Where assistant surgeon services are appropriate, Anthem BCBS reduces the allowed amount based on the type of assistant surgeon assisting in the surgery.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

**Orthopedic Treatment Decision Support**
If you complete Orthopedic Treatment Decision Support (“Treatment Decision Support” or “TDS”) and use a designated facility for eligible spine (back) and joint (knees and hips) inpatient surgery, the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an in-network provider that is not a designated facility or you have not completed TDS (even if you use an in-network provider or a designated facility), the plan pays 80% of eligible expenses after you satisfy the annual deductible. No coverage for services received from out-of-network providers.

Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant’s spine (back) and joint (knees and hips) inpatient surgery.
HealthPartners:
When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Where assistant surgeon services are appropriate, HealthPartners will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Orthopedic Treatment Decision Support

If you complete Orthopedic Treatment Decision Support (“Treatment Decision Support” or “TDS”) and use a designated facility for eligible spine (back) and joint (knees and hips) inpatient surgery, the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an in-network provider that is not a designated facility or you have not completed TDS (even if you use an in-network provider or a designated facility), the plan pays 80% of eligible expenses after you satisfy the annual deductible. **No coverage for services received from out-of-network providers.**

Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant’s spine (back) and joint (knees and hips) inpatient surgery.
### Infertility and fertility services and treatment

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<td>Available HRA dollars pay 100%, then you pay 20% of eligible covered expenses after you satisfy the deductible. Infertility services and treatment are limited to a lifetime maximum benefit of $25,000. (There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined; see the “Prescription drug benefit” section starting on page 2-127 for more information on prescription drugs.)</td>
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<td><strong>– Gold</strong></td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible. Infertility services and treatment are limited to a lifetime maximum benefit of $25,000. (There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined; see the “Prescription drug benefit” section starting on page 2-127 for more information on prescription drugs.)</td>
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<td>You pay 20% of eligible covered expenses after you satisfy the deductible. Infertility services and treatment are limited to a lifetime maximum benefit of $25,000, in-network and out-of-network medical services combined. (There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined; see the “Prescription drug benefit” section starting on page 2-127 for more information on prescription drugs.)</td>
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</table>
The medical plans cover

Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover certain professional services for the diagnosis and treatment of infertility (see below for a listing of covered services). Benefits for covered health services related to infertility are limited to a lifetime maximum benefit paid by the medical plan of $25,000 (in-network and out-of-network medical services combined; to determine when out-of-network services are covered, refer to the “Infertility and fertility services and treatment” table on page 2-79). You must be diagnosed with infertility, as defined by your claims administrator, to be eligible for these services. 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 2-127 for more information on prescription drugs.

Services covered under this benefit include:

- Artificial insemination (AI).
- Intruterine insemination.
- ***In vitro fertilization*** (fresh IVF cycle).
  - Only single embryo transfer is covered under HealthPartners administered plan options and services must be received through the HealthPartners High value infertility network.
- 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.
  - Only single embryo transfer is covered under HealthPartners administered plan options and services must be received through the HealthPartners High value infertility network.
- Gamete intrafallopian transfer (GIFT).
  - Only single gamete transfer is covered under HealthPartners administered plan options and services must be received through the HealthPartners High value infertility network.
- Zygote intrafallopian tube transfer (ZIFT).
  - Only single zygote transfer is covered under HealthPartners administered plan options and services must be received through the HealthPartners High value infertility network.
- 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, including collection and preparation of oocyte or sperm, and the medications associated with the collection and preparation of oocyte or sperm. The plan will not pay for donor charges associated with compensation or administrative services.
- Fertility preservation. The plan will cover fertility preservation when diagnosis of cancer is present and treatment is likely to produce infertility or sterility. Coverage is limited to collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of eggs, oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are the responsibility of the member.
- Infertility treatment following the successful reversal of voluntary sterilization (tubal reversal/reanastomosis, vasectomy reversal/vasovasostomy or vasoepididymostomy).

As new services and treatments become available, they will be considered for coverage based on the claims administrator’s policy guidelines.
Not covered

- A surrogate’s pregnancy on your behalf and related obstetric and maternity benefits
- Reversal of voluntary sterilization and any related charges
- Treatment of infertility after unsuccessful reversal of voluntary 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
- Services and prescription drugs for or related to gender selection services
- Services exceeding the lifetime maximum for this benefit
- Social cryopreservation to delay pregnancy for nonmedical reasons or when a diagnosis of cancer is not present
- Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation)
- Infertility treatment following unsuccessful reversal of sterilization

Also, refer to the “Exclusions” section starting on page 2-114.

Notes
Refer to the “Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery” section on page 2-111 for information about covered travel expenses related to infertility and fertility services and treatment.

Refer to the “Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery” section on page 2-111 for information about covered travel expenses related to infertility and fertility services and treatment.
Maternity care

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<td>In-network providers</td>
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<td>HRA-Based Medical Plan</td>
<td>See the “Notes” section starting on page 2-83.</td>
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<tr>
<td>HSA-Based Medical Plan – Gold, Silver</td>
<td>See the “Notes” section starting on page 2-83.</td>
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The medical plans cover
The medical plans cover all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The medical plans will pay benefits for the covered mother and the newborn (provided that you add the child to your medical coverage through Wells Fargo within 60 days of the date of birth; refer to “Chapter 1: An Introduction to Your Benefits”) for an inpatient stay while both are in the hospital, as follows:

- 48 hours from time of delivery for the mother and newborn child following a normal delivery
- 96 hours from time of delivery for the mother and newborn child following a cesarean section delivery

You do not need authorization from the claims administrator if your provider prescribes a hospital stay of this length. However, if your provider determines that a longer stay is required for either the mother or the baby, you must notify your claims administrator as soon as reasonably possible. If you don’t notify the claims administrator that the inpatient stay will be extended, benefits for the extended stay may be reduced.

If the mother agrees, the attending provider may discharge the mother, the newborn child, or both, earlier than these minimum stays.

Refer to the “Preventive care services (eligible preventive care services)” section starting on page 2-99 for information on newborn immunization and routine prenatal care. You must call Team Member Care (formerly known as the HR Service Center) at 1-877-479-3557, option 2, to add your child to your medical plan coverage within 60 days of the date of birth to receive benefits for any charges incurred by the newborn.

For women’s preventive health care services, see the “Women’s preventive health care services” section starting on page 2-112.

Not covered
- Adoption
- Childbirth classes
- A surrogate’s pregnancy on your behalf and related obstetric and maternity benefits

Also, refer to the “Exclusions” section starting on page 2-114.
Notes

HRA-Based Medical Plan (in-network and Out of Area coverage only):
You will pay 10% coinsurance, after you satisfy the annual deductible, for the initial visit to a PCP or OB/GYN, if these charges are submitted with a primary diagnosis code of pregnancy or maternity. For additional maternity-related services, your provider may submit a global bill to the claims administrator for services including routine prenatal and postnatal care and delivery, which is generally submitted postpartum.

- If the provider submits a global bill:
  - The annual deductible applies to the global bill charge.
  - Available HRA dollars pay 100% of eligible expenses for the global bill until HRA dollars are exhausted while you are in the deductible phase, with the exception of prenatal care, covered at 100%.
  - You are required to pay the next portion of the global bill eligible expense until the annual deductible is met.
  - After the annual deductible is met, you pay 10% coinsurance for the remaining portion of the global bill eligible expense, with the exception of prenatal care, covered at 100%.
  - Some services may be nonroutine or not part of the global bill; you will pay the applicable deductible and coinsurance for these services. If these charges are submitted with a primary diagnosis code of pregnancy or maternity, you will pay a 10% coinsurance, with the exception of prenatal care, covered at 100%. You will pay 20% coinsurance for covered health services without a primary diagnosis of pregnancy or maternity.

- Available HRA dollars pay 100% of eligible expenses until the HRA dollars are exhausted, while you are in the deductible phase.
- You are required to pay the next portion of eligible expenses until the annual deductible is met.
- After the annual deductible is met, you pay 10% coinsurance for maternity-related eligible covered expenses billed with a primary diagnosis code of pregnancy or maternity, with the exception of prenatal care, covered at 100%. You will pay 20% coinsurance for covered health services without a primary diagnosis of pregnancy or maternity.

Available HRA dollars will be applied to your deductible responsibility and your coinsurance.

When services are received from an out-of-network provider, you pay the amount above the allowed amount in addition to any applicable office visit deductible and coinsurance. These amounts above the allowed amount do not count toward the annual deductible or to the annual out-of-pocket maximum, and you cannot use HRA dollars to pay for them.

Some prenatal and postnatal care is considered eligible preventive care. See the “Preventive care services (eligible preventive care services)” section starting on page 2-99 for coverage of these services.

HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver (in-network and Out of Area coverage only):
You will pay 10% coinsurance, after you satisfy the annual deductible, for the initial visit to a PCP or OB/GYN, if these charges are submitted with a primary diagnosis code of pregnancy or maternity. For additional maternity-related services, your provider may submit a global bill to the claims administrator for services including routine prenatal and postnatal care and delivery, which is generally submitted postpartum.

- If the provider submits a global bill:
  - The annual deductible applies to the global bill charge.
  - You are required to pay the portion of the global bill eligible expense until the annual deductible is met.
  - After the annual deductible is met, you pay 10% coinsurance for the remaining portion of the global bill eligible expense, with the exception of prenatal care, covered at 100%.
Some services may be nonroutine or not part of the global bill; you will pay the applicable deductible and coinsurance for these services. If these charges are submitted with a primary diagnosis code of pregnancy or maternity, you will pay a 10% coinsurance, with the exception of prenatal care, covered at 100%. You will pay 20% coinsurance for covered health services without a primary diagnosis of pregnancy or maternity.

- If your provider does not submit a global bill and is not required to by the claims administrator:
  - The annual deductible applies to eligible expenses.
  - After the annual deductible is met, you pay 10% coinsurance for maternity-related office visits and covered health services, including lab services, specialist visits, and delivery charges, if the charges are submitted with a primary diagnosis code of pregnancy or maternity, with the exception of prenatal care, covered at 100%.
  - After the annual deductible is met, you pay 20% coinsurance for covered health services without a primary diagnosis of pregnancy or maternity.

When services are received from an out-of-network provider, you pay the amount above the allowed amount in addition to the required deductible and coinsurance. These amounts above the allowed amount do not count toward the annual deductible or the annual out-of-pocket maximum.

Some prenatal and postnatal care is considered eligible preventive care. See the “Preventive care services (eligible preventive care services)” section starting on page 2-99 for coverage of these services.

**UnitedHealthcare:**
In-home midwives, birthing centers, and fetal monitors (including intrauterine devices) are covered with pre-service authorization. Certified midwives are covered on an in-network basis regardless of the provider’s network status.

**Anthem BCBS:**
Anthem BCBS covers one home health care visit within four days of discharge from the hospital if either the mother or the newborn child is confined for a period less than the 48 hours for normal delivery or 96 hours for cesarean delivery, as mentioned above. See the “Home health care” section starting on page 2-72.
## Mental health and substance abuse residential treatment

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### The medical plans cover

Residential treatment is considered inpatient hospital care. Pre-service authorization is required for all inpatient hospital care. However, it is strongly recommended that you call the applicable claims administrator before receiving any related services to ensure that the services you seek are covered under the plan. In addition, you can get information about in-network providers available in your area (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover mental health and substance abuse licensed residential treatment services that are provided in a facility or a freestanding residential treatment center that provides overnight mental health services or substance abuse treatment for individuals who do not require acute inpatient care but who do need 24-hour medical supervision.

To be covered, the claims administrator’s residential treatment criteria must be met and the center must include an adequate educational program as determined by the applicable claims administrator at its discretion.

A residential treatment facility is a facility that provides a program of effective mental health services substance use disorder services treatment and that meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator.
- It has or maintains a written, specific, and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board
  - Evaluation and diagnosis
  - Counseling
  - Referral and orientation to specialized community resources
A residential treatment facility that qualifies as a hospital is considered a hospital.

Admission to a residential treatment center is not intended for use as a long-term solution or to maintain the stabilization acquired during treatment in a residential facility or program.

**Not covered**

- Halfway houses, extended care facilities or comparable facilities, foster care, adult foster care, and family child care provided or arranged by the local, state, or county agency
- Services that do not meet the claims administrator’s coverage criteria
- Wilderness or other similar programs

Also, refer to the “Exclusions” section starting on page 2-114.
Nutritional formulas

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<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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The medical plans cover

The medical plans cover certain nutritional formulas only when:

- Used as the definitive treatment of an inborn metabolic disorder, such as phenylketonuria (PKU), or conditions that interfere with nutrient absorption and assimilation, such as eosinophilic enteritis, as deemed medically appropriate and necessary based on the claims administrator’s medical policy
- Used as the sole source of nutrition by enteral feedings, as deemed medically appropriate and necessary based on the claims administrator’s medical policy

The medical plans also cover total parenteral nutrition and intravenous (TPN/IV) therapy, equipment, supplies, and drugs in connection with IV therapy. IV line care kits are covered as durable medical equipment. See the “Durable medical equipment, supplies, and prosthetics” section starting on page 2-63.

Not covered

- Enteral feedings and nutritional formulas, including infant formula (except as previously noted)
- Electrolyte supplements, nutritional supplements, and dietary supplements
- Donor breast milk
- Diets for weight control or treatment of obesity (including liquid diets or food)
- Food, food substitutes, meal replacements, or food supplements of any kind (such as diabetic, low-fat, low-cholesterol, or infant formula)
- Over-the-counter oral vitamins and oral minerals
- Megavitamin and nutrition-based therapy
- Oral vitamins and oral minerals

Also, refer to the “Exclusions” section starting on page 2-114.
## Nutritionists

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
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<tbody>
<tr>
<td></td>
<td>In-network providers</td>
</tr>
<tr>
<td>HRA-Based Medical Plan</td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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<td>* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.</td>
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<td>Indemnity Medical Plan — Anthem</td>
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<td>(only available in Puerto Rico,</td>
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<td>Guam, and the Northern Mariana</td>
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<tr>
<td>Islands (Saipan))</td>
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</tbody>
</table>

### The medical plans cover

The medical plans cover nutritional counseling provided in a physician’s office by an appropriately licensed nutritionist or health care professional when education is required for a disease in which patient self-management is an important component of treatment and when a knowledge deficit exists regarding the disease for which the intervention of a trained health professional is required. Some examples of such medical conditions include:

- Congestive heart failure
- Coronary artery disease
- Diabetes
- Gout
- High cholesterol
- Phenylketonuria (PKU)
- Renal failure
- Severe obstructive airway disease

### Not covered

Nutritional counseling for either individuals or groups (except as stated above), including weight loss programs, health clubs, and spa programs.

Also, refer to the “Exclusions” section starting on page 2-114.
Office visit — primary care physician (PCP)

Note: Physicians who qualify as PCPs are listed below.

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<thead>
<tr>
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<th>Out-of-network providers</th>
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<tr>
<td></td>
<td>You pay 20% of eligible covered expenses, no deductible, for eligible primary care physicians (PCPs); see below for a list of eligible PCPs.</td>
<td></td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% after you satisfy the deductible.</td>
<td>You pay 20% of eligible covered expenses, no deductible, for eligible primary care physicians (PCPs); see below for a list of eligible PCPs.</td>
</tr>
</tbody>
</table>

1. The 20% coinsurance, no deductible, applies only to the PCP office visit charge. Available HRA dollars pay toward your 20% coinsurance.
2. The 20% coinsurance, no deductible, does not apply to services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by a specialist brought in to the PCP office visit to examine, diagnose, or provide you with treatment, even if these additional services are performed within the examination room or the provider’s facility. If you receive any services and supplies during your office visit, those services and supplies may be billed separately from the office visit charge, and the annual deductible and coinsurance will apply to eligible expenses for covered health services. Once you have met your annual deductible, you will pay 20% of eligible expenses for other covered health services associated with your PCP office visit. See the “Physician services — inpatient and outpatient facilities” section starting on page 2-97 for more information.
3. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.
4. For office visit charges billed by an out-of-network provider, the 20% coinsurance, no deductible, only applies to the office visit charge within the allowed amount (eligible expense). When services are received from an out-of-network provider, you pay the amount above the allowed amount (eligible expense) in addition to the coinsurance.

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<td>You pay 40% of eligible covered expenses after you satisfy the deductible.</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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<td>– Silver</td>
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<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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The medical plans cover regular office visits with an eligible primary care physician, which includes:

- Family Medicine physicians
- General Practice physicians
- Internal Medicine physicians
- Nurse Practitioners
- Obstetricians and Gynecologists
- Pediatricians
- Physician Assistants

The 20% coinsurance, no deductible, if applicable, only applies to the eligible expense for the PCP office visit charge. It does not apply to services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or pathology), surgical services, or services performed by a specialist brought in to the PCP office visit to examine, diagnose, or provide you with treatment, even if these additional services are performed within the examination room or the provider’s facility. If you receive any services and supplies during your office visit, those services and supplies may be billed separately from the office visit charge, and the
applicable annual deductible and coinsurance will apply to eligible expenses for covered health services. Refer to the “Outpatient surgery, diagnostic, and therapeutic services” section starting on page 2-94 for more information about what you will pay.

Note: For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home, refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information, pre-service authorization requirements and instructions, and how to order and ship specialty medications from the CVS Caremark Specialty Pharmacy to the physician’s office.

Not covered
• Services from a physician or provider who is not an eligible primary care physician as defined under “The medical plans cover” section starting on page 2-89 are not covered under this provision.
• Services of a Christian Science practitioner or a Christian Science nurse, except as listed in the “Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)” section starting on page 2-76.
• Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by CVS Caremark. Refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information.

Also, refer to the “Exclusions” section starting on page 2-114.

Notes
For obstetrical and gynecological office visits related to pregnancy or maternity care, see the “Maternity care” section starting on page 2-82.
### Office visit — non-primary care physician or specialist

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* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

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### The medical plans cover

The medical plans cover regular office visits with a specialist or other physician or provider who is not defined as an eligible primary care physician (see the “Office visit — primary care physician (PCP)” section starting on page 2-89). Some services may require pre-service authorization (see the “Pre-service authorization requirements” section starting on page 2-44).

Note: For prescription drugs that require administration under the direct supervision of a health care professional, refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information, pre-service authorization requirements and instructions, and how to order and ship specialty medications from the CVS Caremark Specialty Pharmacy to the physician’s office.

### Not covered

- Services of a Christian Science practitioner or a Christian Science nurse, except as listed in the “Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)” section starting on page 2-76.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by CVS Caremark. Refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information.

Also, refer to the “Exclusions” section starting on page 2-114.
## Office visit — outpatient mental health and substance abuse

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<td></td>
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<td>You pay 20% of eligible covered expenses, no deductible.</td>
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1. The 20% coinsurance, no deductible, applies only to the office visit charge. Available HRA dollars pay toward your 20% coinsurance.
2. The 20% coinsurance, no deductible, does not apply to services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or other testing procedures), surgical services, or services performed by a specialist brought in to the office visit to examine, diagnose, or provide you with treatment, even if these additional services are performed within the examination room, office, or the provider’s facility. If you receive any services and supplies during your office visit, those services and supplies may be billed separately from the office visit charge, and the annual deductible and coinsurance will apply to eligible expenses for covered health services. Once you have met your annual deductible, you will pay 20% of eligible expenses for other covered health services associated with your office visit. See the “Physician services — inpatient and outpatient facilities” section starting on page 2-97 for more information.
3. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.
4. For office visit charges billed by an out-of-network provider, the 20% coinsurance, no deductible, only applies to the office visit charge within the allowed amount (eligible expense). When services are received from an out-of-network provider, you pay the amount above the allowed amount (eligible expense) in addition to the coinsurance.

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<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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<tr>
<td><strong>– Silver</strong></td>
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<td><strong>Indemnity Medical Plan — Anthem</strong> (only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan))</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible responsibility.</td>
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</table>

### The medical plans cover

The medical plans cover outpatient office visits (including couples counseling) for professional mental health and substance abuse services for evaluation, crisis intervention, and treatment of mental and nervous disorders as described in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Note: Residential treatment, structured outpatient care, and partial hospitalizations are not covered under the outpatient services benefit. These services are considered inpatient care; see the "Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)" section starting on page 2-76.

Office visits for ABA services are not covered under these “Office visit — outpatient mental health and substance abuse” benefits. All services related to ABA are considered under the “Autism coverage” section starting on page 2-54.

Covered health services and supplies are based on the coverage criteria or medical policy of the claims administrator. Contact the claims administrator for information.
For the HRA-Based Medical Plan (in-network and Out of Area coverage only), the 20% coinsurance, no deductible, if applicable for outpatient mental health or substance abuse office visits only applies to the eligible expense for the office visit charge. It does not apply to services and supplies you may receive in connection with your office visit, including but not limited to diagnostic services (for example, lab work, x-rays, MRI, or other testing procedures), or services performed by a specialist brought in to the office visit to examine, diagnose, or provide you with treatment, even if these additional services are performed within the examination room, office, or the provider's facility. If you receive any services and supplies during your office visit, those services and supplies may be billed separately from the office visit charge, and the applicable annual deductible and coinsurance will apply to eligible expenses for covered health services. Refer to the “Outpatient surgery, diagnostic, and therapeutic services” section starting on page 2-94 and the “Psychological and neuropsychological testing” section starting on page 2-102 for more information.

**Not covered**
Refer to the “Exclusions” section starting on page 2-114.
### Outpatient surgery, diagnostic, and therapeutic services

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<td>In-network providers</td>
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<td>Out of Area</td>
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</table>

1. If you need eligible spine (back) and joint (knees and hips) procedures, refer to the “Orthopedic treatment decision support” section on page 2-43.
2. These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

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<td><strong>HSA-Based Medical Plan</strong></td>
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<tr>
<td>Gold</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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<tr>
<td>Silver</td>
<td>You pay 40% of eligible covered expenses after you satisfy the deductible.</td>
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</table>

### The medical plans cover

The medical plans cover outpatient surgery, diagnostic, and therapeutic services received on an outpatient basis in a physician’s office, at a clinic, and at a hospital or alternate facility including:

- Diabetes outpatient self-management training and education, including medical nutrition therapy.
- Scheduled surgery, anesthesia, and related services.
- Scopnic procedures — outpatient diagnostic and therapeutic.
  - Diagnostic scopnic procedures are those for visualization, biopsy, and polyp removal. Examples of diagnostic scopnic procedures include colonoscopy, sigmoidoscopy, and endoscopy.
  - Benefits do not include inpatient surgical scopnic procedures. Benefits for inpatient surgical scopnic procedures are covered in the “Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)” section starting on page 2-76.
- Radiation and chemotherapy.
- Kidney dialysis (both hemodialysis and peritoneal dialysis).
- Lab.
- X-ray.
- Medical education services include medical education services that are provided on an outpatient basis by appropriately licensed or registered health care professionals when education is required for a disease in which patient self-management is an important component of treatment, and where a knowledge deficit exists regarding the disease for which the intervention of a trained health professional is required.

For women’s preventive health care services, see the “Women’s preventive health care services” section starting on page 2-112.
Not covered
• Surgery that is intended to allow you to see better without glasses or other vision correction, including radial keratotomy, laser, and other refractive eye surgery.
• Prescription drugs that do not require administration under the direct supervision of a health care professional. The prescription drug benefit is administered by CVS Caremark. Refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information.

Also, refer to the “Exclusions” section starting on page 2-114.

Notes
UnitedHealthcare:
You must contact UnitedHealthcare for pre-service authorization before you receive the following services:
• CT or CAT scans (computer-aided tomography)
• Dialysis
• Imaging cardiac stress tests
• MRI scans (magnetic resonance imaging)
• Mammography testing
• PET scans, MRI, MRA, nuclear medicine, and major diagnostic services (in-network physicians are required to get a high-tech radiology notification)
• Prescription drugs that require administration under the direct supervision of a health care professional

If you use an in-network or an out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.

Where assistant surgeon services are appropriate, UnitedHealthcare will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Anthem BCBS:
You must contact Anthem BCBS for pre-service authorization before you receive the following services:
• CT or CAT scans (computer-aided tomography)
• Imaging cardiac stress tests
• MRI scans (magnetic resonance imaging)
• Mammography testing
• PET, MRI, and MRA scans, nuclear medicine, and major diagnostic services (in-network physicians are required to get a high-tech radiology notification)

When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Where assistant surgeon services are appropriate, Anthem BCBS reduces the allowed amount based on the type of assistant surgeon assisting in the surgery.

HealthPartners:
When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Where assistant surgeon services are appropriate, HealthPartners reduces the allowed amount based on the type of assistant surgeon assisting in the surgery.

If you complete Orthopedic Treatment Decision Support (“Treatment Decision Support” or “TDS”) and use a designated facility for eligible spine (back) and joint (knees and hips) outpatient surgery, the plan pays 100% of eligible expenses after you satisfy the annual deductible. If you use an in-network provider that is not a designated facility or you have not completed TDS (even if you use an in-network provider or a designated facility), the plan pays 80% of eligible expenses after you satisfy the annual deductible. No coverage for services received from out-of-network providers.

Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant’s spine (back) and joint (knees and hips) outpatient surgery.
### Palliative care

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The medical plans cover palliative care. Palliative care includes symptom management, education, and establishing goals for care if you have a medical condition with a prognosis of a life expectancy of two years or less.

Not covered

Refer to the “Exclusions” section starting on page 2-114.
### Physician services — inpatient and outpatient facilities

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<td>40% of eligible covered expenses after you satisfy the deductible.</td>
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<td>Out of Area* coverage</td>
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</tr>
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<td>– Silver</td>
<td>You pay 40% of eligible covered expenses after you satisfy the deductible.</td>
</tr>
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<td>Out of Area* coverage</td>
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<th>Plan</th>
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<tbody>
<tr>
<td><strong>Indemnity Medical Plan — Anthem</strong> (only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan))</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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</tbody>
</table>

**The medical plans cover**

- Physician services, which include:
  - Allergy testing, serum, and injections administered by a health care professional that are not self-injectable
  - Inpatient hospital or facility visits
  - Outpatient hospital or facility visits
- Surgery:
  - For UnitedHealthcare, if you use an in-network or an out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.
  - For UnitedHealthcare, where assistant surgeon services are appropriate, they 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.
  - For HealthPartners and Anthem BCBS, when more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced. Where assistant surgeon services are appropriate, HealthPartners and Anthem BCBS reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.
  - Anesthesia administered by a provider other than the operating, delivering, or assisting provider is covered.
- Treatment of eye disease
- Diabetes outpatient self-management training and education, including medical nutrition therapy
- Inpatient hospital or facility visits during a covered admission

Note: For prescription drugs that require administration under the direct supervision of a health care professional, refer to the "Prescription drug benefit" section starting on page 2-127 for coverage information, pre-service authorization requirements and instructions, and how to order and ship specialty medications from the CVS Caremark Specialty Pharmacy to the outpatient facility administering the specialty medication.
**Not covered**

- Charges for a physician who does not perform a service but is on call.
- Routine physical examinations not required for health reasons, including but not limited to employment, insurance, government license, court-ordered, forensic, or custodial evaluations.
- Services of a Christian Science practitioner or nurse.
- 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.
- Repair of scars and blemishes on skin surfaces.
- Separate charges for pre- and postoperative care for surgery.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by CVS Caremark. Refer to the “Prescription drug benefit” section starting on page 2-127 for coverage information.

Also, refer to the “Exclusions” section starting on page 2-114.

**Notes**

Services coded by your provider as received in an outpatient facility will be subject to the outpatient facility coinsurance (not the office visit coinsurance).
Preventive care services (eligible preventive care services)

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<td>Out-of-network providers</td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses (you are not required to meet the annual deductible before eligible preventive care services are covered).</td>
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<td>Out of Area* coverage</td>
<td>The medical plan pays 100% of eligible covered expenses.</td>
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<td>The medical plan pays 100% of eligible covered expenses.</td>
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<td>- Silver</td>
<td>You pay 40% of eligible covered expenses (you are not required to meet the annual deductible before eligible preventive care services are covered).</td>
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<td>The medical plan pays 100% of eligible covered expenses.</td>
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</table>

The medical plans cover eligible in-network preventive care services at 100%.

Note: For in-network services, expenses are not deducted from your HRA and you do not need to satisfy the deductible. If you use out-of-network providers while enrolled in an HRA-Based Medical Plan, eligible preventive care services are not subject to the out-of-network deductible, your HRA dollars pay 100% until HRA dollars are exhausted, then you pay 40% of the eligible covered expense.

For a service to be considered an eligible preventive care service, it must be a preventive care service recommended by one of several federal government or independent agencies responsible for the development and monitoring of various U.S. preventive care guidelines. Many of the guidelines take into account gender, age, and your or your family’s medical history.

Preventive care services for children

As recommended under the Bright Futures guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics, the types of services for children covered as preventive care services include but are not limited to:

- Well-baby care physical exams
- Well-child care physical exams
- Vision and hearing screenings
- Developmental assessments
- Screening for depression and obesity
- Obesity counseling
- Preventive eye exam for the following conditions: glaucoma, macular degeneration, and diabetes
Routine vaccines
As recommended by the Centers for Disease Control’s Advisory Committee on Immunization Practices, the types of routine vaccines covered as preventive care services include but are not limited to:

- Routine childhood immunizations such as diphtheria, tetanus, pertussis, polio, chicken pox, measles, mumps, rubella, hepatitis A and B, pneumococcal, meningococcal, rotavirus, human papillomavirus, and flu
- Routine vaccinations for adults such as flu, pneumococcal, tetanus, diphtheria, and zoster

Preventive care services for adults
The types of services that are covered as preventive care services for adults include but are not limited to:

- Adult routine physical exams
- Routine screenings such as blood pressure, cholesterol, and diabetes
- Routine screenings such as mammography (including 3D), colonoscopy, pap smear, and PSA test
- Routine gynecological exams
- Bone density tests
- Routine prenatal care and exams
- Screening for depression and obesity
- Obesity counseling
- Preventive eye exam for the following conditions: glaucoma, macular degeneration, and diabetes

When the claim is filed with the claims administrator, the claim information will indicate the type of services you received. If the claim is coded as an eligible preventive care service with a routine diagnosis code, the claim will be paid as a preventive care service.

If you receive eligible preventive care services at the same time you receive other nonpreventive care services, the nonpreventive care services will be subject to the plan cost-sharing, including the deductible and coinsurance. For example, if you see your provider for a recurring medical problem but also receive an eligible preventive care service, the provider may code the claim as a nonpreventive care office visit. However, the services may be filed on separate claims coding: one for the preventive care services and one for the nonpreventive services or treatments.

If the primary purpose of your visit is for preventive care services (such as an annual physical exam) but you also discuss other health problems during the visit (such as a recurring medical problem), your provider may code the claim as an eligible preventive care service or separate claims may be filed for the preventive and nonpreventive services or treatments.

If you have questions about how claims for your office visit, screenings, lab work, tests, or procedures will be coded, talk to your provider about the type of care you receive or are recommended to receive before the claim is filed with the claims administrator. Once the claim is filed, the claim will be processed based on how your provider coded the claim; that is, services coded by your provider as routine services will be processed as routine services.

For additional information on preventive care coverage under your medical plan, visit the claims administrator’s website or call the claims administrator’s member services department (see the “Contacts” section on page 2-3). Also see the “Women’s preventive health care services” section starting on page 2-112 for more information on women’s preventive health care services.

Not covered
- Adult eye exams with the exception of what is noted above
- Services that are not recommended by one of several federal government or independent agencies responsible for the development and monitoring of various U.S. preventive care guidelines
- Although recommended by one of several government or independent agencies responsible for the development and monitoring of U.S. preventive care guidelines, services that do not follow the government or independent agency’s age, gender, or family history recommended guidelines
- Services coded by the provider as nonroutine, which may include but are not limited to:
  - Office visits, screenings, lab work, tests, or procedures to diagnose a condition, treat a specific illness, or monitor an existing condition
  - Additional office visits, lab work, tests, or procedures recommended or required as a result of a preventive care visit, lab work, test, or procedure
  - Office visits, screenings, lab work, tests, or procedures if a condition or diagnosis is detected
  - Part of the services received that are coded as nonroutine (for example, office visits, lab work, tests, or procedures)
• Nonroutine exams
• Nonroutine vaccinations and immunizations
• Physical exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the medical plans when:
  – Required solely for purposes of career, education, sports or camp, employment, insurance, marriage, or adoption
  – Related to judicial or administrative proceedings or orders
  – Conducted for purposes of medical research
  – Required to obtain or maintain a license of any type
Also, refer to the “Exclusions” section starting on page 2-114.
## Psychological and neuropsychological testing

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<td><strong>HRA-Based Medical Plan</strong></td>
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**The medical plans cover**

The medical plans cover psychological and neuropsychological testing when conducted for the purpose of diagnosing a mental disorder in the most recent version of the DSM (*Diagnostic and Statistical Manual of Mental Disorders*) or in connection with treatment of such a mental disorder. **It is strongly recommended that you call the applicable claims administrator before receiving services** to ensure that the services you seek are covered under the plan. In addition, you can get information about in-network providers available in your area. See the “Pre-service authorization requirements” section starting on page 2-44 for the contact information.

**Not covered**

- Testing to diagnose or rule out a learning disorder or disability
- Physical, psychiatric, or psychological exams, testing, or treatments that are otherwise covered under the medical plans when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage, or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type

Also, refer to the “Exclusions” section starting on page 2-114.
## Reconstructive surgery

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<td><strong>HSA-Based Medical Plan</strong></td>
<td><strong>In-network providers</strong> You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
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</table>

The medical plans cover

Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover certain reconstructive procedures. Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part to address the following:

- Prompt repair of accidental injury that occurs while covered under the medical plan
- To improve function of a malformed body part
- To correct a defect caused by infection or disease

The medical plans also cover the cost of postmastectomy reconstructive surgery performed on you or your eligible covered dependents in a manner determined in consultation with the attending physician and patient for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas
Not covered

- Cosmetic procedures, including but not limited to surgery, pharmacological regimens, nutritional procedures or treatments, scar or tattoo removal, or revision procedures, or skin abrasion
- Liposuction
- Removal of excess skin or fat, or both, after weight loss (regardless of medical need)
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure
- 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
- Dentures, regardless of the cause or condition, and any associated services or charges, including bone grafts
- Dental implants and any associated services and charges
- Repair of scars and blemishes on skin surfaces

Also, refer to the “Exclusions” section starting on page 2-114.

Notes

UnitedHealthcare:
If you use an in-network or out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.

Where assistant surgeon services are appropriate, UnitedHealthcare will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Anthem BCBS and HealthPartners:
When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; the eligible expense for each subsequent procedure may be reduced.

Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

Where assistant surgeon services are appropriate, HealthPartners and Anthem BCBS reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.
### Skilled nursing facility

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<tr>
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<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses after you satisfy the deductible, with a 100-day limitation per plan year, in-network and out-of-network services combined.</td>
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### The medical plans cover

Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover an inpatient stay in a skilled nursing facility or acute inpatient rehabilitation facility. Benefits are limited to 100 days per plan year for skilled nursing, in-network and out-of-network services combined. There are no limits for acute inpatient rehabilitation services that meet the claims administrator’s coverage policy criteria and are billed as acute inpatient rehabilitation services.

Benefits are available for:

- Services and supplies received during the inpatient stay
- Room and board in a semiprivate room (a room with two or more beds)

Skilled nursing provides benefits if you are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation, and facility services that are less than those of a general acute hospital but greater than those available in the home setting.

Benefits are available only when skilled nursing, rehabilitation services, or both, are needed on a daily basis. Benefits are not available when these services are required intermittently (such as physical therapy three times a week).
**Not covered**

- Custodial, domiciliary, or maintenance care (including administration of internal feeds), even when ordered by a physician. Custodial, domiciliary, or maintenance care includes but is not limited to help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs. It is primarily required to meet the patient's personal needs or maintain a level of function, as opposed to improving that function to allow for a more independent existence.

- Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

- Services that do not require continued administration by trained medical personnel to be delivered safely and effectively.

- Treatment, services, or supplies that do not meet the definition of a covered health service.

- Private-duty nursing.

Also, refer to the “Exclusions” section starting on page 2-114.

**Notes**

If you move during the plan year, resulting in a change in your claims administrator, the 100-day limit per plan year will start over under the new claims administrator.
Therapy (outpatient physical therapy, occupational therapy, speech therapy, pulmonary therapy, cardiac therapy, and vision therapy)

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<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible, limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.</td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses after you satisfy the deductible, limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.</td>
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<td>You pay 20% of eligible covered expenses after you satisfy the deductible, limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.</td>
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The medical plans cover

Services may be subject to pre-service authorization requirements (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). Generally, the medical plans cover the following types of outpatient therapy services:

- Physical therapy
- Occupational therapy
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

The therapy services must be performed by a licensed therapy provider, under the direction of a physician. Benefits are limited to 90 visits of speech therapy, occupational therapy, and physical therapy combined (the 90-visit maximum is for in-network and out-of-network services combined), per plan year. There are no limitations for pulmonary or cardiac rehabilitation therapy.

Rehabilitation services are only covered to restore previously attained function lost due to injury or illness. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of
the start of treatment. After an initial evaluation visit, chart notes and an updated treatment plan, including a progress report with measurable objectives and how those objectives have been or will be met, are necessary to validate progress and the need for future visits, whether the provider is an in-network provider or an out-of-network provider.

**Habilitative services** are covered for congenital, developmental, or medical conditions that have significantly limited the successful initiation of normal speech and normal motor development in children, per the claims administrator’s established medical policy. Habilitative speech therapy, physical therapy, and occupational therapy are available for children up to their 18th birthday.

After an initial evaluation visit, chart notes and an updated treatment plan, including a progress report with measurable objectives and how those objectives have been or will be met, are necessary to validate progress and the need for future visits, whether the provider is an in-network or out-of-network provider.

Vision therapy involves a range of treatment modalities, including lenses, prisms, filters, occlusion, eye exercises, and orthoptics that are used for eye movement and fixation training. The goal of vision therapy is to correct or improve specific visual dysfunctions, such as amblyopia, strabismus, and disorders of accommodation and convergence. Benefit is limited to 20 visits combined for in-network and out-of-network services. Vision therapy is only covered for treatment of the following conditions and diagnoses up to age 18:

- Orthoptic or pleoptic training for diagnosis of amblyopia or exotropia, with continued medical direction and evaluation

**Not covered**

- Therapy services that do not meet the claims administrator’s criteria guidelines.
- Therapy for voice modulation or similar training (including to teach people to speak another language). Articulation when it’s the sole focus of therapy and not related to a neurological motor planning disorder.
- Habilitative therapy for those age 18 or older.
- Therapy to improve general physical condition or performance.
- Therapy that has not been approved by the claims administrator.
- Any type of therapy, service, or supply for the treatment of a condition when the therapy, service, or supply ceases to be therapeutic treatment; therapy is excluded if it is administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring, or if objective measurable progress is not being documented.

- Hippotherapy.
- Prolotherapy.
- Eye exercise or vision therapy for those age 18 or older.

Also, refer to the “Exclusions” section starting on page 2-114.

**Notes**

If you move during the plan year, resulting in a change in your claims administrator, the 90-visit limit (combined therapies) per plan year will start over under the new claims administrator.
## Transplant services

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<tr>
<td>Gold</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
<td>You pay 40% of eligible covered expenses after you satisfy the deductible.</td>
<td>You pay 20% of eligible covered expenses after you satisfy the deductible.</td>
</tr>
<tr>
<td>Silver</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indemnity Medical Plan — Anthem</strong></td>
<td>(only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan))</td>
</tr>
</tbody>
</table>

### The medical plans cover

Pre-service authorization is required (see the “Pre-service authorization requirements” section starting on page 2-44 for more information). If pre-service authorization is received, the medical plans cover organ, bone marrow, and tissue transplants as explained below.

Covered health services and supplies for the following organ or tissue transplants are payable when ordered by a physician. The claims administrator must be notified at least seven working days before the scheduled date of any of the following, or as soon as reasonably possible:

- Evaluation
- Donor search
- Organ procurement or tissue harvest
- Organ transplants

In case of an organ or tissue transplant, donor charges are considered covered health services only if the recipient is a covered person. If the recipient is not a covered person, no benefits are payable for donor charges.

The search for bone marrow or stem cells from a donor who is not biologically related to the patient is not considered a covered health service unless the search is made in connection with a transplant procedure arranged by a designated facility.

If a qualified procedure is a covered health service and performed at a designated facility, the medical care, treatment, transportation, and lodging provisions apply.

Qualified procedures include but are not limited to the procedures listed below. The claims administrator’s medical policies determine if a procedure is a qualified procedure.

- Heart
- Heart and lung
- Liver
- Lung (single or double)
- Pancreas for a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session, or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired
• Kidney
• Liver and kidney
• Intestine
• Liver and intestine
• Cornea — you are not required to notify the plan administrator of a cornea transplant, nor is the cornea transplant required to be performed at a designated facility
• Bone marrow and stem cells
• Pancreas
• Kidney and pancreas
• Other transplant procedures when the claims administrator determines that it is medically appropriate to perform the procedure at a designated facility

Medical care and treatment — the covered expenses for services provided in connection with the transplant procedure include:
• Pretransplant evaluation for one of the procedures listed above
• Organ acquisition and procurement
• Hospital and physician fees
• Transplant procedures
• Follow-up care for a period up to one year after the transplant
• Search for bone marrow and stem cells from a donor who is not biologically related to the patient

A designated facility has entered into an agreement with the claims administrator or with an organization contracting on behalf of the medical plans to provide covered health services for the treatment of specified diseases or conditions. A designated facility may or may not be located within your geographic area. To be considered a designated facility, the facility must meet certain standards of excellence and have a proven track record of treating specified conditions as determined by the claims administrator. The fact that a hospital is considered in-network under the medical plan does not mean that it is a designated facility.

Not covered
• Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood-producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary
• Living donor organ or tissue transplants unless otherwise specified in this SPD
• Transportation and lodging expenses not coordinated by the applicable claims administrator
• Expenses in excess of the stated reimbursement or benefit limits
• Nonhuman organ implants or transplants
• Other transplants not specifically listed in this SPD
• Services that would not be performed but for the transplant, even as a result of complications
• Surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of FDA-approved Ventricular Assist Devices (VAD) or an FDA-approved total artificial heart functioning as a temporary bridge to heart transplantation, except as specifically described in the claims administrator’s medical policy
• Treatment of medical complications that may occur to the donor; donors are not considered covered persons, and are therefore not eligible for the rights afforded to covered persons under this SPD
• Benefits for travel and lodging expenses when you are not using a designated facility

Refer to the “Prescription drug benefit” section starting on page 2-127 for prescription drug coverage information and prescriptions that are not covered.

Also, refer to the “Exclusions” section starting on page 2-114.

Notes
Refer to the “Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery” section on page 2-111 for information about covered travel expenses related to transplant surgery. Refer to the “Prescription drug benefit” section starting on page 2-127 for prescription drug coverage information and pre-service authorization requirements and instructions.

HealthPartners:
• Members must use a HealthPartners designated network transplant provider to receive in-network benefits. Pre-service authorization is required before receiving services, and will be requested by this designated network transplant provider. Note that the fact that a facility is considered to be an in-network facility by HealthPartners does not mean that the facility is a designated facility.
Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery

The claims administrator will assist the patient and family with travel and lodging arrangements if the patient meets the criteria to receive services and resides more than 50 miles from a:

- Designated facility
- Qualified provider (as determined by the claims administrator) for gender reassignment services (available only under UnitedHealthcare and HealthPartners)

Expenses for travel and lodging for the covered person and a companion are available as follows:

- Transportation of the patient and one companion who is traveling on the same days to or from the designated facility (as listed above) for the purposes of an evaluation, an approved surgical procedure, or necessary postdischarge follow-up.
- Reasonable and necessary expenses, as determined by the claims administrator, for lodging for the patient and one companion.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed as determined by the claims administrator.
- Eligible spine (back) and joint (knee and hip) surgery have a $2,000 annual combined maximum transportation and lodging reimbursement limit.

Notes

Anthem BCBS:
Anthem BCBS does not provide a travel and lodging benefit for cancer, congenital heart disease, or gender reassignment services.
### Women’s preventive health care services

<table>
<thead>
<tr>
<th>Plan</th>
<th>What you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-network providers</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-network providers</strong></td>
<td></td>
</tr>
<tr>
<td><em><em>Out of Area</em> coverage</em>*</td>
<td></td>
</tr>
<tr>
<td><strong>HRA-Based Medical Plan</strong></td>
<td></td>
</tr>
<tr>
<td>The medical plan pays 100% of eligible covered expenses.</td>
<td>Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses (you are not required to meet the annual deductible before eligible preventive care services are covered).</td>
</tr>
<tr>
<td><strong>HSA-Based Medical Plan</strong></td>
<td></td>
</tr>
<tr>
<td>The medical plan pays 100% of eligible covered expenses.</td>
<td>You pay 40% of eligible covered expenses (you are not required to meet the annual deductible before eligible preventive care services are covered).</td>
</tr>
<tr>
<td><strong>Indemnity Medical Plan — Anthem</strong></td>
<td></td>
</tr>
<tr>
<td>(only available in Puerto Rico, Guam, and the Northern Mariana Islands (Saipan))</td>
<td>The medical plan pays 100% of eligible covered expenses.</td>
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</tbody>
</table>

* These Out of Area benefits are only available if your home ZIP code is designated to be outside of the claims administrator’s network service area and apply to services received from in-network or out-of-network providers.

**The medical plans cover**

The medical plans cover eligible women’s preventive health services as noted in the table above for women for the following:

- Annual well-woman preventive care visit for an adult woman to obtain recommended preventive services that are age and developmentally appropriate
- Contraceptive methods, including sterilization procedures and patient education and counseling for a woman with reproductive capacity for the following:
  - Diaphragms, cost of diaphragm billed by physician and charge for fitting
  - Implantable and injectable contraceptives, cost of medication billed by physician and injection charges
  - Tubal ligation procedure
  - Intrauterine devices (IUDs), cost of IUD and charge for placement or removal
  - Generic contraceptive prescriptions (see the “Prescription drug benefit” section starting on page 2-127)
- 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 Indemnity Medical Plan — Anthem BCBS and HRA-Based Medical Plan Out of Area coverage, you are not required to use an in-network hospital, physician, or durable medical equipment (DME) supplier)

– For breast-feeding equipment, the plan does not cover any of the following:
  ° Breast pumps purchased through any out-of-network hospital, physician, or DME supplier (except as noted above)
  ° Items purchased from a retail store
  ° Additional supplies, including but not limited to storage containers and freezer packs

• High-risk human papillomavirus DNA testing in a woman with normal cytology results, beginning at age 30, limited to once every three years

• Annual counseling and screening visit for human immune-deficiency virus (HIV) infection for a sexually active woman

• Annual screening and counseling for interpersonal and domestic violence

Note: When the claim is filed with the claims administrator, the claim information will indicate the type of services you received. If the claim is coded as an eligible women’s preventive health care service as described above with a routine diagnosis code, the claim will be paid as a women’s preventive health care service. Office visit charges billed separately without a preventive diagnosis code are not covered under these provisions (see the “Office visit — primary care physician (PCP)” section starting on page 2-89 and the “Office visit — non-primary care physician or specialist” section on page 2-91).

If you receive eligible women’s preventive health care services at the same time you receive other nonpreventive care services, the nonpreventive care services will be subject to the plan cost-sharing, including the deductible and coinsurance applicable to the type of service received.

If you have questions about how claims for your office visit, tests, or procedures will be coded, talk to your provider about the type of care you receive or are recommended to receive before the claim is filed with the claims administrator. Once the claim is filed, the claim will be processed based on how your provider coded the claim.

The following may be covered under the Plan but are not considered services covered under women’s preventive health care services:

• Services not coded as preventive care services or coded as nonroutine services

• Digital breast tomosynthesis (3D mammography)

• Services not listed above

• Services beyond the frequency limits listed above

• Abortion services

• Over-the-counter items

Also, refer to the “Exclusions” section starting on page 2-114.
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, naturopathy, 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 services” section on page 2-74.

**Experimental, investigational, or unproven services**

The fact that an experimental or investigational service or an unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition, as determined by the applicable claims administrator.

**Experimental or investigational procedure**

These include medical, surgical, diagnostic, mental health, substance abuse, or other health care services, technologies, supplies, treatments, procedures, 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**

- Where 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
- Where the conclusions determine that the treatment, service, or supply is not effective
- Where 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
- 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
- Wigs, regardless of the reason for the hair loss
- Removal of excess skin or fat, or both, after weight loss (regardless of medical need)
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 himself or herself

• Services performed by a provider with your same legal residence

• Charges made by a physician for or in connection with surgery that exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure and one half of the amount otherwise payable for all other surgical procedures

• Services performed by an unlicensed provider or a provider who is operating outside of the scope of his or her license or certification

• Services provided at a diagnostic facility (hospital or free-standing) without a written order from a provider

• Services that are ordered by a provider affiliated with a diagnostic facility (hospital or free-standing) when that provider is not actively involved in your medical care:
  – Before ordering the service
  – After the service is received
This exclusion does not apply to mammography testing.

Services provided under another plan or program

• Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements, including but not limited to coverage required by Workers’ Compensation, no-fault auto insurance, or similar legislation

• If coverage under Workers’ Compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness, or mental illness that would have been covered under Workers’ Compensation or similar legislation had that coverage been elected

• Health services for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you

• Charges payable under Medicare

• Charges that the participant is entitled to payment by a public program other than Medicaid

Travel

• Health services provided in a foreign country, unless required as emergency health services

• Travel, transportation, or living expenses, whether or not services are prescribed by a physician

• Travel, transportation, or living expenses, whether or not recommended or prescribed by a physician, except as specified in the “Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery” section on page 2-111

• 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 2-127 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; however, the purchase of the first pair of contact lenses that follows cataract surgery will be covered
• 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
• Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient’s medical condition would deteriorate
• 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” section on page 2-88
• 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
• Growth hormone therapy (see the “Prescription drug benefit” section starting on page 2-127 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 2-49 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 for snoring, except when provided as a part of treatment for documented obstructive sleep apnea

• 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 or sexual dysfunction devices, except for gender reassignment surgery

• Personal comfort items, such as telephone, television, barber and beauty supplies, and guest services

• Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the medical plan when:
  - Required solely for purposes of career, education, sports or camp, employment, insurance, marriage, or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type

• Private-duty nursing (see the “Extended skilled nursing care” section starting on page 2-67 for more information)

• Private room charges when facility has a semiprivate room available

• Prolotherapy

• Psychosurgery

• Repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage, or gross neglect, even if prescribed by a physician

• Replacement of lost or stolen prosthetic devices, even if prescribed by a physician

• Respite care with the exception of hospice care

• Rest cures

• Reversal of voluntary sterilization

• Routine vision screening after age 17

• Services a provider gives to himself or herself 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 2-109

• 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 gene therapy as a treatment for inherited or acquired disorders

• 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 2-112 or required by applicable law

• Services for or related to tobacco cessation program fees or related program supplies (see the “Rally Missions (Take action)” section on page 2-39 and “Telephonic wellness coaching (Take action)” section on page 2-39 for information about tobacco cessation programs)

• Services or confinements ordered by a court or law enforcement officer that do not meet the definition of a covered health service, including but not limited to custody evaluation, parenting assessment, education classes for DUI offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs, except as otherwise indicated in the “Women’s preventive health care services” section starting on page 2-112 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 2-76)

• 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

• Treatment of excessive sweating (hyperhidrosis)

• Treatment of benign gynecomastia (abnormal breast enlargement in males)

• Treatment where payment is made by any local, state, or federal government (except Medicaid) or for which payment would be made if the member had applied for such benefits

• 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)

• Ultrasonic nebulizers, even if prescribed by a physician
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 2-44.

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.

<table>
<thead>
<tr>
<th>Claims administrator</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare</td>
<td>Phone: 1-800-842-9722</td>
</tr>
<tr>
<td>Anthem BCBS</td>
<td>Phone: 1-866-418-7749</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>Phone: 952-883-5800 or 1-800-942-4872</td>
</tr>
</tbody>
</table>

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 2-44.

<table>
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<tr>
<th>Claims administrator</th>
<th>Contact</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare</td>
<td>Phone: 1-800-842-9722</td>
<td>UnitedHealthcare&lt;br&gt;PO Box 30884&lt;br&gt;Salt Lake City, UT 84130</td>
</tr>
<tr>
<td>Anthem BCBS</td>
<td>Phone: 1-866-418-7749</td>
<td>Anthem BCBS UM Services, Inc.&lt;br&gt;PO Box 7101&lt;br&gt;Indianapolis, IN 46207</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>Phone: 952-883-6400 or 1-800-316-9807 or you may call Member Services at 952-883-6677 or 1-888-487-4442</td>
<td></td>
</tr>
</tbody>
</table>

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 2-3). Late filing by an out-of-network provider is not a circumstance allowing for submission beyond the stated 12-month time frame.

Mailing addresses for post-service claims

<table>
<thead>
<tr>
<th>Claims administrator</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare</td>
<td>UnitedHealthcare&lt;br&gt;PO Box 30884&lt;br&gt;Salt Lake City, UT 84130</td>
</tr>
<tr>
<td>Anthem BCBS</td>
<td>Anthem Blue Cross Blue Shield&lt;br&gt;PO Box 105187&lt;br&gt;Atlanta, GA 30348</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>Claims Department&lt;br&gt;HealthPartners, Inc.&lt;br&gt;PO Box 1289&lt;br&gt;Minneapolis, MN 55440-1289</td>
</tr>
</tbody>
</table>
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.

Claims payment

HRA-Based Medical Plan

Eligible expenses for covered health services are paid from your HRA when you have funds available. After the HRA dollars are exhausted, you must meet the annual deductible (except for preventive care services) before the HRA-Based Medical Plan pays benefits for covered health services. The date of service determines which year the claim applies to for the purposes of available HRA dollars, annual deductible, and annual out-of-pocket maximums. For additional information on HRA dollars, see the “Health reimbursement account (HRA)” section starting on page 2-13.

For UnitedHealthcare:

When you receive 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 coinsurance or copay. In addition, you must pay for all charges not covered by the HRA-Based Medical Plan. However, you are not responsible for any amounts an in-network provider is required to write off as a result of his or her contract with UnitedHealthcare.

When you receive covered health services from an out-of-network provider, the applicable out-of-network (or if applicable, the Out of Area coverage) 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 HRA-Based Medical 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:

When you receive covered health services from an in-network provider, the in-network level benefit payment (or if applicable, Out of Area coverage benefit payment) is issued to the in-network provider. You are responsible for the applicable in-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 HRA-Based Medical Plan. However, you are not responsible for any amounts an in-network provider is required to write off as a result of his or her network contract.

When you receive covered health services from an out-of-network provider, the applicable out-of-network (or if applicable, the Out of Area coverage) 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.

For HealthPartners:
When you receive 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 coinsurance or copay. In addition, you must pay the full cost of all charges not covered by the HRA-Based Medical Plan. However, you are not responsible for any amounts an in-network provider is required to write off as a result of his or her contract with HealthPartners.

When you receive covered health services from an out-of-network provider, HealthPartners will assume that you have provided an Assignment of Benefits (AOB) and will pay any applicable out-of-network (or if applicable, the Out of Area coverage) benefits directly to the out-of-network provider for the services received unless you provide proof to HealthPartners when you file the claim that you have already paid the provider in full for the charges incurred. In that case, HealthPartners will issue any applicable benefit payment to you. Whether benefits are paid to you or to the out-of-network provider, you are responsible for the applicable out-of-network (or if applicable, the Out of Area coverage) annual deductible and coinsurance. In addition, you must pay the full cost of all charges not covered by the HRA-Based Medical 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.

HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver (including Out of Area coverage)
You must meet your annual deductible (except for preventive care services) before the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver pays benefits for covered health services.

For UnitedHealthcare:
When you receive 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 coinsurance. In addition, you must pay the full cost of all charges not covered by the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver. However, you are not responsible for any amounts an in-network provider is required to write off as a result of his or her contract with UnitedHealthcare.

When you receive covered health services from an out-of-network provider, the applicable out-of-network (or if applicable, the Out of Area coverage) 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. In addition, you must pay the full cost of all charges not covered by the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver.

Note: An assignment to pay the out-of-network provider generally does not assign any other rights under the Health Plan to that out-of-network provider, including the right to request plan documents or pursue and appeal an adverse benefit determination on your behalf.

For Anthem BCBS:
When you receive 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 issued to the in-network provider. You are responsible for the applicable in-network (or if applicable, the Out of Area coverage) annual deductible and coinsurance. In addition, you must pay the full cost of all charges not covered by the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver. However, you are not responsible for any amounts an in-network provider is required to write off as a result of his or her network contract.

When you receive covered health services from an out-of-network provider, the applicable out-of-network (or if applicable, the Out of Area coverage) benefits are paid to you; there is no assignment of benefits except as noted below. You must pay the out-of-network provider in full for 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.

For HealthPartners:
When you receive 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 coinsurance. In addition, you must pay the full cost of all charges not covered by the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver. However, you are not responsible for any amounts an in-network provider is required to write off as a result of his or her contract with HealthPartners.

When you receive covered health services from an out-of-network provider, HealthPartners will assume that you have provided an Assignment of Benefits (AOB) and will pay any applicable out-of-network (or Out of Area) benefits directly to the out-of-network provider for the services received unless you provide proof to HealthPartners when you file the claim that you have already paid the out-of-network provider in full for all charges incurred. In that case, HealthPartners will issue any applicable benefit payment to you. Whether benefits are paid to you or to the out-of-network provider, you are responsible for the applicable out-of-network (or if applicable, the Out of Area coverage) annual deductible and coinsurance. In addition, you must pay the full cost of all charges not covered by the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver.

Note: An assignment to pay the out-of-network provider generally does not assign any other rights under the Health Plan to that out-of-network provider, including the right to request plan documents or pursue and appeal an adverse benefit determination on your behalf.

Indemnity Medical Plan — Anthem BCBS
You must meet your annual deductible (except for preventive care services) before the Indemnity Medical Plan — Anthem BCBS pays benefits for covered health services.

When you receive covered health services from an in-network provider, the benefits are paid to the in-network provider directly. You are responsible for the deductible and coinsurance. In addition, you must pay the full cost of all charges not covered by the Indemnity Medical Plan — Anthem BCBS. However, you are not responsible for any amounts an in-network provider is required to write off as a result of his or her network contract.

The benefit payment for covered health services received from an out-of-network provider is issued 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 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.

Claim denials and appeals
If you have a question or concern about a claim, you may call the applicable claims administrator:

• UnitedHealthcare at 1-800-842-9722
• Anthem BCBS at 1-866-418-7749
• HealthPartners at 1-888-487-4442 or in the Twin Cities metro area at 952-883-6677

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.”
Disputes and complaints for HealthPartners

**Determination of coverage**

Eligible services are covered only when necessary for the proper treatment of a covered person as determined by HealthPartners in accordance with the applicable plan provisions. Decisions about medical necessity, restrictions on access, and appropriateness of treatment are made by HealthPartners' medical director or his or her designee.

If your claim for medical services was denied based on HealthPartners' clinical coverage criteria, you or your provider can discuss the decision with a clinician who reviewed the request for coverage. Call Member Services for assistance.

**Complaints**

HealthPartners has a complaint procedure to resolve complaints and disputes. Complaints may be made verbally or in writing. They may concern the provision of care by in-network providers, administrative actions, or claims, including breach, meaning, or termination. The complaint system seeks to resolve a dispute that arose during the time of your coverage, or application for coverage.

Complaints must be made to:

- HealthPartners Member Services Department
  8170 33rd Ave
  PO Box 1309
  Minneapolis, MN 55440-1309
  Telephone: 952-883-6677
  Outside the metro area: 1-888-487-4442

**Right of recovery**

The HRA-Based Medical Plan, HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver, and Indemnity Medical Plan – Anthem BCBS, as well as the CVS Caremark administered prescription drug benefit, are 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 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 claims. 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 promptly inform the Health Plan in writing of any situation or circumstance that may allow the Health Plan to invoke its rights under this section.

**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, judgment, award, or otherwise, on account of injury or medical condition. 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:
• 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.

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.

**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

CVS Caremark administers the prescription drug benefits offered under the:

- HRA-Based Medical Plan*
- HSA-Based Medical Plan – Gold*
- HSA-Based Medical Plan – Silver*
- Indemnity Medical Plan – Anthem BCBS

* Including Out of Area. Unless otherwise indicated, references in this “Prescription drug benefit” section to the HRA-Based Medical Plan or the HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver also apply to the applicable Out of Area coverage.

Coverage is determined based on CVS Caremark’s 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 CVS Caremark Advanced Drug List (a listing of preferred drugs), is covered, or is subject to certain prescription drug benefit provisions, visit caremark.com or call Customer Care at 1-800-772-2301.

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 CVS Caremark Retail Program. When you have a prescription filled at an in-network retail pharmacy, you’ll typically pay less than if you have a prescription filled at a nonparticipating pharmacy.

Maintenance medications

Maintenance medications are those you take on a regular, ongoing basis for chronic, long-term conditions such as those used to control blood pressure. This does not include drugs your doctor prescribes for a short-term condition, such as antibiotics.

You may fill up to two 30-day maintenance prescriptions at any retail pharmacy. After the second fill, you will need to switch to 90-day supplies from the CVS Caremark Mail Service Pharmacy, a CVS Pharmacy store, or a CVS Pharmacy inside a Target store. If you would like to continue to receive 30-day supplies, contact CVS Caremark before your third fill. If you do not switch to 90-day supplies after two fills, or opt out by calling CVS Caremark, your prescription will not be covered.

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, multiple sclerosis, growth hormone disorders, and immune deficiencies. The medications are often injectable or intravenously (IV) infused, but may also be in oral or inhaled form. 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 the CVS Specialty Pharmacy, or you can arrange to pick them up at a CVS Pharmacy store or a CVS Pharmacy inside a Target store. See the “CVS Caremark Specialty Pharmacy” section on page 2-135 for more information.

Filling your prescription at a retail pharmacy

Bring your CVS Caremark ID card and pay your portion, as shown in the “What you’ll pay for prescriptions: HRA-Based Medical Plan and the Indemnity Medical Plan — Anthem BCBS” table on page 2-132, or in the “What you’ll pay for prescriptions: HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver” table on page 2-133, 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” section starting on page 2-135 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 CVS Caremark. If it’s a covered prescription, CVS Caremark will reimburse you as shown in the “What you’ll pay for prescriptions: HRA-Based Medical Plan and the Indemnity Medical Plan — Anthem BCBS” table on page 2-132, or in the “What you’ll pay for prescriptions: HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver” table on page 2-133, for up to a 30-day supply per prescription, depending on the medical plan in which you are enrolled.
To locate a CVS Caremark participating pharmacy:
• Visit CVS Caremark’s website at caremark.com.
• Call Customer Care at 1-800-772-2301.

Filling maintenance medications at a CVS Pharmacy store or a CVS Pharmacy inside a Target store
You can get an 84- to 90-day supply of most prescription drugs that you take on a regular basis at a CVS Pharmacy store. Exceptions include self-injectables (excluding insulin), drugs that require special handling, and oral chemotherapy drugs. See the “CVS Caremark Specialty Pharmacy” section on page 2-135 for more information.

You will pay one copay or coinsurance amount as applicable (see the “What you’ll pay for prescriptions: HRA-Based Medical Plan and the Indemnity Medical Plan — Anthem BCBS” table on page 2-132, or the “What you’ll pay for prescriptions: HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver” table on page 2-133).

To get started, ask your doctor to write a prescription for an 84- to 90-day supply when clinically appropriate and present this prescription to a CVS Pharmacy store. Any prescription written for 83 days or less will not apply to this benefit. Only a 30-day supply will be dispensed and you will be responsible for the retail copay or coinsurance amount. A 30-day supply limit applies to all other retail pharmacies.

Filling your prescription through CVS Caremark Mail Service
CVS Caremark Mail Service is available for most prescriptions that you take on a regular basis. You can order up to a 90-day supply of your prescription. You must use the CVS Caremark Mail Service or a CVS Pharmacy to fill maintenance medications after you receive two 30-day fills. If you would like to continue to receive 30-day fills, contact CVS Caremark to make this request. Consult with your doctor regarding your prescription if you intend to use the CVS Caremark Mail Service Pharmacy. You will generally pay less if your prescription covers a 90-day supply with three refills than if it covers a 30-day supply with 11 refills.

With CVS Caremark Mail Service, you get:
• 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 mail order, certain medications are not available through mail order, 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 CVS Caremark. If your quantity is limited based on clinical guidelines or by a CVS Caremark program, your copay amount or coinsurance (including coinsurance maximum) may be prorated, as determined by CVS Caremark.

Ordering prescriptions
Once you have filled a prescription through CVS Caremark Mail Service, 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 CVS Caremark.

Three ways to order prescriptions:
• Online. Go to caremark.com. If you are a first-time visitor, you’ll need to register using your CVS Caremark ID number (shown on your CVS Caremark ID card).
• By phone. (existing prescriptions only)
  Call Customer Care at 1-800-772-2301 for fully automated refill service. Have your CVS Caremark ID number ready.
• By mail.
  – For existing prescriptions:
    Complete a mail service order form (available on caremark.com), attach the refill label provided with your last order, and enclose your payment with your order.
  – For new prescriptions:
    Complete a mail service order form (available on caremark.com), send it to CVS Caremark along with your prescription, and enclose your payment with your order.
You can expect your medicine to arrive approximately 10 calendar days after CVS Caremark 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 mail service 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 mail order cannot be returned. You will be responsible for the applicable cost-share for prescription drugs you or your physician order via mail order.

In-network out-of-pocket maximums
If you enroll in the HRA-Based Medical Plan or the Indemnity Medical Plan — Anthem BCBS, your out-of-pocket maximum will be $1,000 for individual, $1,600 for individual plus spouse, $1,300 for individual plus child, or $1,900 for family for all eligible in-network prescription drug expenses and no one individual will pay more than $1,000 in annual, in-network, out-of-pocket prescription drug expenses. There is no out-of-pocket maximum for prescriptions purchased from an out-of-network pharmacy.

Expenses for all covered members accrue toward the applicable coverage level (for example, you + spouse) annual out-of-pocket maximum. The annual in-network out-of-pocket maximum can be met by any combination of covered members. No one individual will pay more than $1,000 in annual, in-network, out-of-pocket prescription drug expenses. Also, the annual in-network out-of-pocket maximum for midyear enrollments is not prorated.

Note: The prescription drug in-network out-of-pocket maximum does not apply to the HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver. See the “Annual out-of-pocket maximum” section starting on page 2-9 for more information.

Covered prescriptions
For your prescription to be covered, it must meet CVS Caremark’s 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 prior authorization or prior approval), 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 as they are introduced.

No cost-share preventive medications
The Affordable Care Act (ACA) requires that certain medications be covered at 100%. The following list of prescription drug classes and specific over-the-counter medications may be available to you with no cost-share. Only certain products within a class may be covered, or you may be asked to try a generic product before a brand name will be covered. Coverage is subject to ACA requirements, clinical guidelines, and all other plan provisions. Note: A prescription is required for all claims, including over-the-counter items.

- Aspirin products for women 12 years to 59 years and men 50 years to 59 years
- Female contraceptives (see the “Women’s preventive health care services” section starting on page 2-112)
• Folic acid for women under age 55
• Fluoride supplements for children
• 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 CVS Caremark)
• Vitamin D supplements for men and women age 65 or older
• 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 2-99 and the “Women’s preventive health care services” section starting on page 2-112 for information about other covered preventive care under the medical plan.

Compound drugs

The copay or coinsurance amount 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. All compound drugs with a total cost of $300 or greater require prior authorization. See the “Some prescriptions may require pre-service authorization” section starting on page 2-135 for more information.

Diabetic supplies and medications

You can purchase drugs and supplies to control your diabetes for one copay or coinsurance amount when you submit prescriptions for the diabetic supplies at the same time as your prescription for insulin or oral diabetes medication, or when you submit prescriptions for multiple insulins or oral diabetic medications, to CVS Caremark Mail Service Pharmacy, or an 84- to 90-day supply at a CVS Pharmacy store. Common diabetic supplies include lancets, test strips, alcohol swabs, and syringes or needles. The copay or coinsurance amount you pay will depend on the type of diabetes medication or supplies prescribed. Your copay or coinsurance is based on the highest-cost drug or supply. If you purchase diabetic supplies or diabetic medications at any other retail pharmacy, separate copays or coinsurance amounts will apply to each item.

Some diabetic medications, insulins, and supplies are subject to pre-service authorization requirements. (See the “Some prescriptions may require pre-service authorization” section starting on page 2-135 for more information.)

Note: The above diabetic supplies and medications payment provision does not apply to the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver. If, under either of the HSA-Based Medical Plans, you purchase diabetic supplies and diabetic medications, you will pay coinsurance for each drug or supply on the preventive therapy drug list without having to meet the deductible. If your drug or supply is not on the preventive therapy drug list, you must meet the annual deductible before benefits are available.

Infertility drugs

Medications to treat infertility are covered up to a lifetime maximum benefit of $10,000. You will pay the applicable deductible, copay, or coinsurance for the medication. The cost of the medication covered by the Plan applies to the lifetime maximum benefit. Most infertility medications are subject to pre-service authorization requirements. (See the “Some prescriptions may require pre-service authorization” section starting on page 2-135 for more information.) Medications for donors and partners (for example, suppression medications or stimulation medications) are not covered.

Advanced Drug List

Certain prescription drugs are included on the CVS Caremark Advanced Drug List (a listing of preferred drugs). This list, sometimes called a formulary, includes a wide selection of generic and brand-name drugs. CVS Caremark maintains the CVS Caremark Advanced Drug List, including ensuring that the list is reviewed and updated regularly by an independent pharmacy and therapeutics committee. The list is continually revised by CVS Caremark to ensure that the most up-to-date information is taken into account. Go to caremark.com or call 1-800-772-2301 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 the 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. CVS Caremark 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 Advanced Drug List as determined by CVS Caremark.

  These drugs may or may not have generic equivalents available.

- **Nonpreferred brand-name drugs.** Brand-name prescription drugs that are not on the Advanced Drug List as determined by CVS Caremark.

  You'll generally pay more for nonpreferred brand-name drugs covered under the plan.

- **Biosimilars.** A biosimilar product is a biological product that is approved based on a showing that it is highly similar to an already-approved biological product. The biosimilar also must show it has no clinically meaningful differences in terms of safety and effectiveness. Only minor differences in clinically inactive components are allowable in biosimilar products.
What you’ll pay for prescriptions: HRA-Based Medical Plan and the Indemnity Medical Plan — Anthem BCBS

You do not pay a deductible for prescription drugs and prescription drug costs do not count toward your deductible or medical annual out-of-pocket maximum. In addition, HRA dollars, if available, are not applied to the cost of the drugs. See the “Important terms” section starting on page 2-8 for more information about the annual deductible and annual out-of-pocket maximum. See the “No cost-share preventive medications” section starting on page 2-129 for information about certain preventive drugs covered at 100%.

<table>
<thead>
<tr>
<th>Type of drug</th>
<th>In-network retail pharmacy (up to a 30-day supply)</th>
<th>Out-of-network retail pharmacy (up to a 30-day supply)</th>
<th>CVS Caremark Mail Service (up to a 90-day supply) or CVS Pharmacy store (84- to 90-day supply)</th>
</tr>
</thead>
</table>
| Generic drugs                 | You pay a $7 copay.                               | You pay a $7 copay plus the difference between the full cost and the CVS Caremark discounted amount. | You pay a $14 copay. Note: Generic contraceptives are covered at 100%.
|                               | Note: Generic contraceptives are covered at 100%. |                                                      |                                                                                                |
| Preferred brand-name drugs    | You pay 50%, up to a maximum of $75 per prescription. | You pay 50%, up to a maximum of $110 per prescription, plus the difference between the full cost and the CVS Caremark discounted amount. | You pay 50%, up to a maximum of $150 per prescription. |
| Nonpreferred brand-name drugs | You pay 50%, up to a maximum of $110 per prescription. | You pay 50%, up to a maximum of $110 per prescription, plus the difference between the full cost and the CVS Caremark discounted amount. | You pay 50%, up to a maximum of $220 per prescription. |
| Maximum annual out-of-pocket for in-network prescriptions (This is distinct and separate from your annual out-of-pocket maximum for covered medical services. No one individual will pay more than $1,000 in annual, in-network, out-of-pocket prescription drug expenses,) | $1,000 per individual. $1,600 for individual plus spouse.* $1,300 for individual plus children. $1,900 per family. | $1,000 per individual. $1,600 for individual plus spouse.* $1,300 for individual plus children. $1,900 per family. | $1,000 per individual. $1,600 for individual plus spouse.* $1,300 individual plus children. $1,900 per family. |

* For the purposes of this chapter, the term "spouse" includes your domestic partner, unless otherwise noted.
**What you’ll pay for prescriptions: HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver**

You must satisfy your applicable annual deductible under the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver before you begin paying the coinsurance amounts listed in the table below, unless your drug is on the preventive therapy drug list. Go to caremark.com or call CVS Caremark at 1-800-772-2301 to see if your prescription is considered to be a preventive therapy drug. Your prescription costs, including the annual deductible, apply to your annual out-of-pocket maximum. See the “**Important terms**” section starting on page 2-8 for more information about the annual deductible and annual out-of-pocket maximum. See the “**No cost-share preventive medications**” section starting on page 2-129 for information about certain preventive drugs covered at 100%.

<table>
<thead>
<tr>
<th>Type of drug</th>
<th>In-network retail pharmacy (up to a 30-day supply)</th>
<th>Out-of-network retail pharmacy (up to a 30-day supply)</th>
<th>CVS Caremark Mail Service (up to a 90-day supply) or CVS Pharmacy store (84- to 90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications on the preventive therapy drug list — generic, preferred brand, and nonpreferred brand</td>
<td>You pay 20% of covered charges; no deductible applies. Note: Generic contraceptives are covered at 100%.</td>
<td>You pay 20% of the contracted rate plus the difference between the full cost and the CVS Caremark discounted amount. Note: Generic contraceptives are covered at 100%.</td>
<td>You pay 20%; no deductible applies.</td>
</tr>
<tr>
<td>Nonpreventive medications — generic, preferred brand, and nonpreferred brand</td>
<td>You pay 20% of covered charges after you satisfy the deductible.</td>
<td>You pay 20% of the contracted rate plus the difference between the full cost and the CVS Caremark discounted amount.</td>
<td>You pay 20% after you satisfy the deductible.</td>
</tr>
</tbody>
</table>
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).

Go to caremark.com or call 1-800-772-2301 to see if your prescription is considered to be a preventive therapy drug. See the “No cost-share preventive medications” section starting on page 2-129 for information about certain preventive drugs covered at 100%.

Additional prescription drug coverage provisions

The following provisions also apply to all prescription drug claims processing under the HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, the HSA-Based Medical Plan – Silver, and the Indemnity Medical Plan – Anthem BCBS:

• 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 contraceptives, filled at an in-network retail pharmacy, are covered at 100%. If there is a clinical reason that you cannot take a generic contraceptive, your doctor can submit a request to CVS Caremark for review. If the request is approved, your brand-name contraceptive will be covered at 100%. Your doctor can fax the request to the CVS Caremark Appeals Department at 1-866-689-3092.

• If you purchase a brand-name drug when a generic equivalent is available, you will pay the generic copay or coinsurance, 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 CVS Caremark's 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 CVS Caremark 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 CVS Caremark Appeals Department at 1-866-689-3092.

• There are no exceptions to any other copay or coinsurance amounts listed, even with a physician’s request. For example, if the drugs on the Advanced 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 or coinsurance amount.

• Prescriptions for certain specialty drugs (typically self-injectables, drugs that require special handling, or oral chemotherapy drugs) cannot be filled at retail pharmacies. For more information, see the “CVS Caremark Specialty Pharmacy” section on page 2-135.

• CVS Caremark Mail Service is the only covered mail order provider. Any drugs ordered by mail from another provider or service will not be covered.

• Certain prescriptions have quantity limits based on FDA, manufacturer, or clinical guidelines, as determined by CVS Caremark.

• You’ll need to request pre-service authorization from CVS Caremark for certain prescriptions. For more information, see the “Some prescriptions may require pre-service authorization” section starting on page 2-135.

Your ID card

Shortly after you enroll in the HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, the HSA-Based Medical Plan – Silver, or the Indemnity Medical Plan – Anthem BCBS, you’ll receive an ID card from CVS Caremark. 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 CVS Caremark.

You can also go to caremark.com to print a temporary ID card.
CVS Caremark 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. CVS Caremark Specialty Pharmacy is a comprehensive pharmacy program that provides these products directly to covered individuals along with supplies, equipment, and care coordination.

Contact CaremarkConnect toll-free at 1-888-346-4945 to get:

- Personal attention from experts
- Expedited, confidential delivery to the location of your choice
- A pharmacist-led or nurse-led CareTeam 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
- Pharmacists who are available 24 hours a day for emergency consultations
- Coordination of home care and other health care services
- Arrangements to drop off or pick up your specialty medication at a CVS Pharmacy store or a CVS Pharmacy inside a Target store

Certain specialty medications may not be available through the CVS Caremark 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: HRA-Based Medical Plan and the Indemnity Medical Plan — Anthem BCBS” table on page 2-132 or the “What you’ll pay for prescriptions: HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver” table on page 2-133 for more information.

Certain specialty drugs have limits on the quantity that can be dispensed, as determined by CVS Caremark. If your quantity is limited based on clinical guidelines or by a CVS Caremark program, your copay amount or coinsurance (including coinsurance maximum) may be prorated, as determined by CVS Caremark.

Some prescriptions may require pre-service authorization

With most of your prescriptions, no pre-service authorization is necessary. However, some prescriptions require that you get authorization from CVS Caremark 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 prior authorization or prior approval. Many of the drug classes requiring pre-service authorization are listed on the next page. Contact CVS Caremark to determine if your prescription requires pre-service authorization; visit caremark.com, sign on, and click Prescriptions and Coverage, or contact Customer Care at 1-800-772-2301. Note that prescriptions may fall under one or more pre-service authorization coverage review programs described below.

When you receive a prescription, take it to your retail pharmacy or send it to your CVS Caremark Mail Service Pharmacy as described in this chapter. If pre-service authorization is necessary, your pharmacist or CVS Caremark will let you know. If pre-service authorization is required, the provider who prescribed the medication must call 1-800-626-3046 to submit pertinent information to CVS Caremark that is necessary for the pre-service authorization review.

After the review is complete, CVS Caremark will send you and your doctor a letter confirming whether coverage has been approved (usually within 48 hours after CVS Caremark 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: HRA-Based Medical Plan and the Indemnity Medical Plan — Anthem BCBS” table on page 2-132 or the “What you’ll pay for prescriptions: HSA-Based Medical Plan – Gold and HSA-Based Medical Plan – Silver” table on page 2-133. 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 CVS Caremark in its sole discretion. Drugs with quantity limits are also subject to pre-service authorization review.
The list of drugs 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 CVS Caremark. The following table provides information about many of the drug classes subject to these requirements.

<table>
<thead>
<tr>
<th>Drug class or condition treated</th>
<th>Pre-service authorization required</th>
<th>Step therapy required</th>
<th>Quantity limits apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne medications</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Acromegaly</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Alcohol and opioid dependency</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Anabolic steroids</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Analgesics</td>
<td>X</td>
<td></td>
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<tr>
<td>Anemia</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antiandrogens</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Anticonvulsants</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Antiemetics (treat nausea and vomiting)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Antifungals, oral</td>
<td>X</td>
<td></td>
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<tr>
<td>Antifungals, topical</td>
<td>X</td>
<td></td>
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<tr>
<td>Antiobesity medications</td>
<td>X</td>
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<tr>
<td>Asthma</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Attention deficit hyperactivity disorder (ADHD)</td>
<td>X</td>
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<tr>
<td>Beta blocker combinations</td>
<td>X</td>
<td></td>
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<tr>
<td>Botulinum toxins</td>
<td>X</td>
<td></td>
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<tr>
<td>Cancer treatments</td>
<td>X</td>
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<tr>
<td>Cardiac disorder</td>
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<tr>
<td>Carnitine deficiency agents</td>
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<tr>
<td>Central precocious puberty (CPP)</td>
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<tr>
<td>Cholesterol medications</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>CNS — Huntington’s disease</td>
<td>X</td>
<td></td>
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<tr>
<td>Coagulation disorders (affect blood clotting)</td>
<td>X</td>
<td></td>
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<tr>
<td>Colony stimulating factors</td>
<td>X</td>
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<td></td>
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<tr>
<td>Corticosteroids</td>
<td>X</td>
<td></td>
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<tr>
<td>Cryopyrin-associated periodic syndromes (CAPS)</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Cushing’s syndrome</td>
<td>X</td>
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<tr>
<td>Cystic fibrosis</td>
<td>X</td>
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<tr>
<td>Depression</td>
<td>X</td>
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<td></td>
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<tr>
<td>Dermatology</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes medications</td>
<td>X</td>
<td></td>
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<tr>
<td>Electrolyte disorders</td>
<td>X</td>
<td></td>
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<tr>
<td>Drug class or condition treated</td>
<td>Pre-service authorization required</td>
<td>Step therapy required</td>
<td>Quantity limits apply</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Emphysema</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Enlarged prostate</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Fertility, see “Infertility” row below</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fibrates</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Gastrointestinal disorders</td>
<td>X</td>
<td></td>
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<tr>
<td>Glaucoma</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Gout</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Growth hormone</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Hematopoietics</td>
<td>X</td>
<td></td>
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<tr>
<td>Hemophilia</td>
<td>X</td>
<td></td>
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<tr>
<td>Hepatitis C</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Hereditary angioedema</td>
<td>X</td>
<td></td>
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<tr>
<td>High blood pressure (ACEI/ARB)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Hormonal therapies</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idiopathic Thrombocytopenic Purpura (ITP) (platelet disorder)</td>
<td>X</td>
<td></td>
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<td>Urinary antispasmodics</td>
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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 30-day supplies of maintenance medications obtained at a retail pharmacy after two fills, without calling CVS Caremark to opt out of 90-day supplies.
- Any drug used to enhance athletic performance.

- 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 not approved for the method of administration, unless otherwise approved by CVS Caremark based on clinical criteria as determined by CVS Caremark 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 CVS Caremark 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 CVS Caremark Mail Service or from a CVS Pharmacy store. You’ll be responsible for any copays or coinsurance amounts.

• Investigational or experimental drugs in original or compounded form, as determined by CVS Caremark in its discretion.

• Mail order prescriptions that are not filled at a CVS Caremark Mail Service facility.

• More than a 30-day supply of a prescription drug at a retail pharmacy, except a CVS Pharmacy store, even if there is not a CVS Pharmacy store in your area.

• New drugs or new formulations of drugs that have not been reviewed by CVS Caremark for safety, efficacy, and cost-effectiveness unless approved by CVS Caremark based on clinical criteria as determined by CVS Caremark 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; CVS Caremark must receive claims within 12 months of the prescription drug dispensed date.

• Prescriptions exceeding a reasonable quantity as determined by CVS Caremark in its discretion.

• Prescriptions requested or processed after your coverage ends; you must be an active participant in the HRA-Based Medical Plan, the HSA-Based Medical Plan — Gold, the HSA-Based Medical Plan — Silver, or the Indemnity Medical Plan — Anthem BCBS 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 CVS Caremark’s coverage criteria.

• Prescriptions that do not meet the definition of a covered health service (see the “Covered health services definition” section starting on page 2-49).

• Replacement of lost or stolen medication.

• Sexual dysfunction drugs.

• Topical antifungal polishes (such as Penlac).

The following drugs are not covered by CVS Caremark 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 caremark.com, sign on, and click Prescriptions and Coverage. Or contact Customer Care at 1-800-772-2301.
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 CVS Caremark for reimbursement after any other payer has paid primary or has made the initial payment for the covered drugs.

If you or a covered dependent is covered under the HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, the HSA-Based Medical Plan – Silver, or the Indemnity Medical Plan – Anthem BCBS, 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 CVS Caremark ID card and submit out-of-pocket copay or coinsurance expenses to Medicaid or other similar state programs.

Prescription drug claims and appeals

CVS Caremark 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, fax your request to 1-888-836-0730 or call 1-800-772-2301.

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, fax your pre-service claim request to 1-888-836-0730 or call 1-800-626-3046.

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 CVS Caremark network or if the in-network pharmacy was unable to submit the claim successfully. All claims must be received by CVS Caremark 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 caremark.com, log in, and download the claim form.
• Call Customer Care at 1-800-772-2301 to request a form.

Send your claim to:

CVS Caremark
PO Box 52136
Phoenix, AZ 85072-2136

You are responsible for any charges incurred but not covered.

Refer to “Appendix A: Claims and Appeals” for more information regarding claims.

CVS Caremark claims questions, denied coverage, and appeals

If you have a question or concern about a claim already filed with CVS Caremark, you may contact Customer Care at 1-800-772-2301.
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 CVS Caremark 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.”

**Other things you should know**

**Clinical Management Programs**

Through a series of safety checks, Enhanced Retrospective Safety Review, Enhanced Safety and Monitoring Solution, and Drugs Savings Review help ensure that your prescription drug treatment is appropriate for your health situation. If these safety checks reveal a potential problem, a CVS Caremark pharmacy professional or representative will directly contact your physician to review your treatment, and sometimes suggest a change to the current therapy.

CVS Caremark 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.

Through the Enhanced Safety and Monitoring Solution, the program looks for overutilization or inappropriate usage of medication that has the potential to be addictive. Through this program, the plan reserves the right to take the following actions:

- Limit your use of retail pharmacies
- Limit the number of prescribers for a medication
- Contact your prescribers directly

For medication to work properly, you must take it correctly. That’s why CVS Caremark also reviews medications that require you to take multiple doses (based on frequency per day or number of tablets or capsules per dose) and, if appropriate, may suggest ways to make it easier for you to take your medication properly. For example, it may be possible to reduce the number of times you must take your medication each day without changing the total daily dosage.

**CVS Caremark 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 CVS Caremark). 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 CVS Caremark).

You’re not limited to prescriptions on CVS Caremark’s Advanced 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 Advanced Drug List but there’s an alternative on the list, CVS Caremark 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 Advanced 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, CVS Caremark 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 a CVS Caremark pharmacist to discuss your therapy and provide condition and drug-specific counseling.

**Prescription drug rebates**

CVS Caremark administers the prescription drug benefit on behalf of the Wells Fargo & Company Health Plan. The HRA-Based Medical Plan, the HSA-Based Medical Plan – Gold, the HSA-Based Medical Plan – Silver, and the Indemnity Medical Plan — Anthem BCBS are all components of the Wells Fargo & Company Health Plan. CVS Caremark has negotiated certain rebates and discounts with participating retail pharmacies and drug manufacturers. CVS Caremark has agreed that the Health Plan may receive the benefit of these rebates and discounts.

To the extent the Health Plan receives discounts or rebates based on CVS Caremark’s negotiated rebates and discounts, including the receipt of rebate payments in connection with prescription drugs purchased 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

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<td><a href="https://www.deltadentalmn.org/wf">https://www.deltadentalmn.org/wf</a></td>
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<td>Minneapolis and St. Paul Metro Area: 651-994-5342</td>
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<td>All other areas: 1-877-598-5342</td>
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| Information about the dental plan options | Teamworks |

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| Information about premiums | Check your enrollment materials, or go to Teamworks. |
The information in this chapter — along with "Chapter 1: An Introduction to Your Benefits," "Appendix A: Claims and Appeals," "Appendix B: Important Notifications and Disclosures," "Appendix D: Leaves of Absence and Your Benefits," and "Appendix E: Continuing Coverage Under COBRA" — constitutes the Summary Plan Description (SPD) for the dental benefit option available under the Wells Fargo & Company Health Plan (the Health Plan). The dental benefit option is also referred to as the dental plan.

The basics

General information
The dental plan is a part of the Wells Fargo & Company Health Plan. The Wells Fargo & Company Health Plan is a group health plan and is classified as a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA). There are two dental coverage options:

• Delta Dental Standard
• Delta Dental Enhanced

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

The dental plan and respective coverage options, administered by Delta Dental, are available in all U.S. locations.

The dental plan covers preventive, diagnostic, basic, and major services, as well as orthodontia, for you and your covered dependents.

If you are enrolled in either Delta Dental coverage option, you agree to authorize your provider to give Delta Dental access to required information about your care. Your failure to provide this authorization or any requested information may result in denial of your claim. Delta Dental may require this information to process claims, to conduct quality improvement and utilization review activities, or for other health plan activities, as permitted by law. Delta Dental may release the information, if you authorize it to do so, or if state or federal law permits or allows release without your authorization.

Who's eligible
Regular and part-time Wells Fargo team members are eligible to enroll in the dental plan. If you are enrolled as an eligible team member, you may also cover your eligible dependents including your spouse or domestic partner. However, you may not be covered under the dental plan as both a team member and spouse or domestic partner, or a team member and a dependent child at the same time. Also, a dependent can only be covered under one team member. Detailed eligibility requirements are described in the "Who's eligible to enroll" section in "Chapter 1: An Introduction to Your Benefits."

How to enroll and when coverage begins
Refer to the "How to enroll" section in "Chapter 1: An Introduction to Your Benefits" for the time frame and process for enrollment. After you have enrolled, coverage will begin as described in the "When coverage begins" section in "Chapter 1: An Introduction to Your Benefits."

Changing or canceling coverage
You may make changes to your enrollment election during the Annual Benefits Enrollment period or if you experience certain Qualified Events during the year. For more information on making enrollment election changes, refer to the "Changing coverage" section in "Chapter 1: An Introduction to Your Benefits."

When coverage ends
Dental coverage for you or any enrolled dependents ends as described in the "When coverage ends" section in "Chapter 1: An Introduction to Your Benefits."

Cost
You contribute to pay for the cost of dental coverage. For more information, refer to the "Cost and funding" section in "Chapter 1: An Introduction to Your Benefits."

Claims administrator
The dental plan is self-insured, and Delta Dental is the claims administrator providing administrative claims services. Delta Dental is the named claims and appeals fiduciary for the dental plan and has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the dental plan and the respective coverage options.

How the Delta Dental coverage options work
Although you may use any provider you want, you’ll pay less, in most cases, when you use a Delta Dental participating provider because network providers agree to accept Delta Dental’s contracted network fee (“allowable fee”) as the maximum charge for a procedure. The two networks of participating providers are the Delta Dental PPOSM network and the Delta 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 Premier networks. However, providers in the Delta Dental PPO network have generally agreed to lower contracted fees than providers in the Delta Premier network. If you have access to providers in both networks, you may pay less out of pocket if you receive services from a Delta PPO provider than you would if you receive them from a Delta Premier network provider.

If you use a Delta Dental PPO network provider or a Delta Dental Premier network provider, you will need to identify yourself as a Delta Dental participant when scheduling an appointment. You will not need to file a claim for reimbursement because the network provider bills Delta Dental. You will be responsible for your portion of the contracted allowable fee. You will also be responsible for the full cost of any services not covered by the dental plan.

If you use an out-of-network provider, you must pay the out-of-network provider for services and then file a claim with Delta Dental. You will be reimbursed for covered services up to the applicable portion of the cost indicated in Delta Dental’s table of allowance. See the “Allowable fees and benefit payments” section on page 3-6 for more information. Benefits will be paid directly to you rather than to the out-of-network provider. You will be responsible for the full cost billed by the out-of-network provider, even if that amount is greater than the Delta Dental allowed amount. For more information on claims and how to obtain a claim form, see the “Claims and appeals” section on page 3-9.

You and all of your covered dependents will receive an ID card from Delta Dental. The ID card includes a subscriber number as your primary identification. The subscriber number is a random (system-generated) member ID that you will need to present when you receive services from a Delta Dental network provider. 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 622
Minneapolis, MN 55440-0622

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 form from Delta Dental within 30 days, contact Delta Dental at 1-877-598-5342.

What the Delta Dental coverage options cover

The dental plan offers two coverage options. Your coinsurance amount, annual benefit maximum, and orthodontia lifetime maximum differ based on the Delta Dental coverage option you've elected.

Your dental benefits and costs at a glance

Benefits are subject to the exclusions and limitations noted in this chapter and you are responsible for all charges not covered by the dental plan. All coinsurance (%) amounts are based on allowable fees and apply only after the annual deductible is met. The annual deductible and annual maximum benefit are also based on allowable fees. See the “Allowable fees and benefit payments” section on page 3-6 for more information on the allowable fees.

<table>
<thead>
<tr>
<th>Benefit features</th>
<th>Delta Dental Standard option</th>
<th>Delta Dental Enhanced option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible</strong></td>
<td>$50 per person.</td>
<td>$50 per person.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Annual maximum benefit</strong></td>
<td>$1,500 per person.</td>
<td>$2,000 per person.</td>
</tr>
<tr>
<td></td>
<td>Diagnostic, preventive care, and orthodontia are not applied to the annual maximum.</td>
<td>Diagnostic, preventive care, and orthodontia are not applied to the annual maximum.</td>
</tr>
<tr>
<td><strong>Diagnostic and preventive care</strong></td>
<td>Covered at 100%.</td>
<td>Covered at 100%.</td>
</tr>
<tr>
<td><strong>Basic care</strong></td>
<td>You pay 20% after your deductible.</td>
<td>You pay 10% after your deductible.</td>
</tr>
<tr>
<td>Fillings and oral surgery</td>
<td>You pay 20% after your deductible for most care. For composite (white) fillings on posterior teeth, you pay 30% after your deductible.</td>
<td>You pay 10% after your deductible for most care. For composite (white) fillings on posterior teeth, you pay 20% after your deductible.</td>
</tr>
<tr>
<td>Periodontics</td>
<td>You pay 20% after your deductible.</td>
<td>You pay 10% after your deductible.</td>
</tr>
<tr>
<td>Endodontics</td>
<td>You pay 20% after your deductible.</td>
<td>You pay 10% after your deductible.</td>
</tr>
<tr>
<td><strong>Major restorative services</strong></td>
<td>You pay 50% after your deductible.</td>
<td>You pay 40% after your deductible.</td>
</tr>
<tr>
<td>Dental implants</td>
<td>You pay 50% after your deductible.</td>
<td>You pay 40% after your deductible.</td>
</tr>
<tr>
<td>Prosthetics and repairs</td>
<td>You pay 50% after your deductible.</td>
<td>You pay 40% after your deductible.</td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td>You pay 50%. There is a $1,500 lifetime maximum benefit per person.</td>
<td>You pay 50%. There is a $2,000 lifetime maximum benefit per person.</td>
</tr>
</tbody>
</table>

1. Diagnostic and preventive care is covered at 100% of allowable fees and is not subject to deductible for services listed in the “Diagnostic and preventive care” section on page 3-6. Any diagnostic or preventive care not listed in that section will not be covered.

2. Orthodontia lifetime benefit based on enrollment in either the Delta Dental Standard or the Enhanced coverage option at time of appliance banding. No additional benefit is payable by changing coverage option from the Standard to Enhanced option or vice versa. Benefits paid under the former Wachovia Dental Program, a component of the former Wachovia Corporation Health and Welfare Plan, are considered when determining the lifetime maximum orthodontia benefit under the Delta Dental Standard or Enhanced coverage options. 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 include services previously received, regardless of coverage or benefits issued at the time of 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 or paid by the dental plan.

**Allowable fees and benefit payments**

Providers who participate in the Delta Dental PPO network or Delta 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 a procedure; this is the allowable fee for services received from a network provider. Participating network providers will file the claim for you and payment will be made directly to the network provider. You will be responsible for any applicable deductible and coinsurance amounts for covered services, as described in the “Your dental benefits and costs at a glance” table on page 3-5. You are also responsible for the full cost of any services not covered by the dental plan.

If you use an out-of-network provider, claim payments are based on the treating provider’s submitted charge or the table of allowances established by Delta Dental, whichever is less (the allowable fee for services received from an out-of-network provider is the lesser of the two). The table of allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed out-of-network provider. When services are received from an out-of-network provider, you must file the claim, and claim payments are sent directly to you. You are responsible for any applicable deductible and coinsurance amounts for covered services, as described in the “Your dental benefits and costs at a glance” table on page 3-5. You are also responsible for all charges not covered by the dental plan. It is your obligation to pay the out-of-network provider for all services received.

**Diagnostic and preventive care**

Both Delta Dental coverage options cover 100% of allowable fees for the following types of preventive care services:

- Bitewing x-rays, one set of decay detecting x-rays limited to once every 12 months
- Consultation, one in a six-month period
- Comprehensive periodontal evaluation, once per plan year
- Diagnostic x-rays and lab procedures required for oral surgery
- Emergency oral exams, up to two per plan year
- Full-mouth x-rays (or panoramic x-ray with or without bitewing x-rays), once every five years
- Palliative treatment for relief of dental pain (excludes prescription medication and temporary or interim procedures)
- Periodic exams, twice in a plan year
- Periodontal maintenance procedure, up to four per plan year, but only after completion of active periodontal therapy
- Sealants or preventive resin restorations for children under age 16 for six- and 12-year permanent molars, once per tooth per lifetime, both procedures combined
- Single-film x-rays as required for specific diagnoses
- Space maintainers for children under age 19 to replace extracted posterior primary teeth only
- Teeth cleaning, twice per plan year
- Topical fluoride applications for children under age 18, once per plan year

**Basic care**

The Standard option covers 80% of the allowable fees and the Enhanced option covers 90% of the allowable fees for basic care services described below (unless otherwise noted). Your coverage begins after satisfying the annual deductible for the following types of restorative care:

- Amalgam fillings, limited to once every two years per surface.
- White fillings for front teeth limited to once every two years per surface.
- Composite (white) fillings for back teeth. The Standard option covers 70% and the Enhanced option covers 80% for composite or resin fillings for back teeth. Limited to once every two years per surface.
Crown lengthening only when Delta Dental, at its sole discretion, determines the procedure to be dentally necessary. Documentation must show insufficient tooth structure above the osseous level to perform restorative treatment. Crown lengthening is not covered for esthetic or cosmetic purposes. It is recommended that a pretreatment estimate be requested to determine if the procedure will be covered before beginning treatment.

Endodontics, treatment of infection of the dental pulp, including root canal work, limited to once every 24 months, per tooth.

Extractions, surgical and nonsurgical — once per tooth.

General anesthesia or intravenous (IV) sedation, or a combination of both, in conjunction with covered complex surgical services (as determined by Delta Dental at its discretion).

Gingivectomy or gingivoplasty on a per-tooth or per-quadrant basis, natural teeth only, limited to once every 90 days; not covered in areas where the natural tooth has been extracted or when performed in conjunction with a restoration on the same tooth.

Composite resin or gold, porcelain, or ceramic inlays; benefit is limited to same surfaces and cost allowances for amalgams; replacement of inlays is limited to once every five years.

Oral surgery, when performed in the provider’s office.

Periodontics (treatment of gum disease), nonsurgical periodontics to treat periodontal disease, limited to once every two years; includes scaling and root planing.

Surgical periodontics treatment performed as necessary to treat periodontal disease, limited to natural teeth; not covered in areas where natural tooth has been extracted.

Major care

The Standard option covers 50% of allowable fees and the Enhanced option covers 60% of allowable fees for the major care services described below. Your coverage begins after satisfying the annual deductible for the following types of major care services:

Addition of teeth to an existing partial or removable denture, to replace a fully extracted permanent adult tooth.

Initial installation of fixed bridgework, including inlays and crowns to form supports to replace a fully extracted permanent adult tooth or teeth; no benefits are available if a benefit for partial or full dentures has been issued for that arch (upper or lower) within the past five years.

Initial installation of removable partial or full dentures (including adjustments during the six-month period after they are installed) to replace a fully extracted permanent adult tooth or teeth, limited to once per arch (upper and lower) every five years.

Night guards, one per lifetime.

Onlays and crowns (gold restorations and crowns are covered as treatment to replace tooth structure lost due to decay or fracture only when teeth cannot be restored with other filling materials); replacement of crown and onlay restorations (or coverage for any other type of restoration on that tooth) is limited to once every five years.

Relines, twice in a 12-month period per arch but not until six months after the initial placement or rebases, once in a 24-month period.

Repairs to existing dentures, once every six months but not until six months after the initial placement.

Replacement of an existing partial or full denture, removable denture, or fixed bridgework, provided that the existing denture or bridgework was installed at least five years before its replacement and meets one of the following conditions:

- The existing denture or bridgework cannot be made serviceable.
- Replacement is made necessary by the placement of an original opposing full denture or the extraction of natural permanent teeth.
- The bridge or denture, while in the oral cavity, was damaged beyond repair by an injury sustained while covered under the Delta Dental coverage options.

Single-tooth implant body, abutment, and crown, once every five years for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment, and implant abutment supported crown. Some adjunctive implant services may not be covered. Therefore, it is recommended that a pretreatment estimate be requested to estimate the amount of payment before beginning treatment.

Veneers used to restore lost tooth structure as a result of tooth decay or fracture on anterior permanent teeth, once every five years per tooth. After a tooth has been restored using a veneer, no other major restoration will be covered on that tooth for five years.

Removable, fixed, or cemented habit-breaking appliances (including adjustment and treatment of appliances), limited to one appliance per covered member.
Orthodontia benefits

The Delta Dental coverage options cover 50% of the allowable fees for eligible orthodontia expenses.

The orthodontia lifetime benefit is based on which Delta Dental coverage option you are enrolled in at the time of appliance banding. No additional benefit is payable by changing coverage option from the Standard to Enhanced option or vice versa. For example, if appliance banding occurred while enrolled in the Standard option, the total lifetime orthodontia benefit will not exceed $1,500. If you change from the Standard option to the Enhanced option and orthodontic work is in progress, any remaining benefit will be paid up to the Standard option’s $1,500 maximum benefit.

If appliance banding occurred before participation in the dental plan, the lifetime maximum is based on the Delta Dental coverage option you are enrolled in when you first receive orthodontia services, unless orthodontia benefits were paid under the former Wachovia Dental Program. The total lifetime orthodontia benefits paid per person, combined with any other orthodontia benefits under the Wells Fargo dental plan or the former Wachovia Dental Program, cannot exceed a total of $1,500 if you’re enrolled in the Standard option, or $2,000 if you’re enrolled in the Enhanced option.

The Delta Dental coverage options cover the following types of orthodontia expenses:

- Preliminary studies for orthodontic programs, including x-rays, diagnostic casts, and recommended treatment schedules
- Limited, interceptive, or comprehensive orthodontia treatment plans, which include all active and retention appliances (when included in the fee); retention is not a separately covered benefit

It is recommended that you obtain a pretreatment estimate, as described under the “Pretreatment estimate” section on page 3-4, so both you and your orthodontist may receive an estimate of what your Delta Dental coverage option will cover. For more information, see the “Orthodontia claims” section on page 3-10.

What is not covered

Charges for some types of dental work will not be covered. 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 the Health Plan ends or 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
- Coronectomy
- Crown lengthening, except as noted in the “Basic care” section on page 3-6
- Cytology sample collection
- Decalcification procedures
- 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
• Pediatric partial denture, fixed
• Periodontal splinting (temporary wiring or permanently bonding teeth together)
• Prescribed medications
• Preventive resin restoration
• Provisional pontic and provisional retainer crown
• Provisional splinting (intracoronal or extracoronal)
• Pulpal regeneration
• Repair or replacement of any orthodontic appliance
• Replacement of existing dentures or bridgework, unless listed in the “Major care” section on page 3-7
• Replacement of lost or stolen prosthetic devices if benefits were previously provided
• Retreatment or additional treatment necessary to correct or relieve the result of treatment previously covered under the Delta Dental coverage options
• Services completed before the date the covered person became eligible for the coverage
• Services not indicated as covered
• Services or supplies not recommended or prescribed by a dentist, orthodontist, or oral surgeon
• Sinus augmentation
• 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 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 his or her 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 filed timely.

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 622
Minneapolis, MN 55440-0622

Providing all needed information when filing a claim can help avoid delays in processing the claim. If the claim is approved, a check is produced, along with an Explanation of Benefits, and both will be issued to you. Delta Dental does not issue payments to out-of-network providers. If the claim is not approved (in whole or in part) or needs additional information, you will receive an Explanation of Benefits indicating the reason for nonpayment.

You are responsible for paying the out-of-network provider in full.

Orthodontia claims
Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of the treatment.

Treatment beginning after coverage is effective
Before services are received, the provider should submit a pretreatment estimate of total cost to Delta Dental. For more information, see the “Pretreatment estimate” section on page 3-4.

After review and approval by Delta Dental, benefits will be estimated. You and your provider will receive an Estimate of Benefits showing the approved services and the estimated benefit amount. Services must begin within 90 days of the approval date. If you or your provider does not receive an Estimate of Benefits within 30 days, contact Delta Dental at 1-877-598-5342.

When the orthodontic appliances are installed, the provider should file the claim by submitting the Estimate of Benefits with the date of placement and the provider's signature to Delta Dental. An out-of-network provider may require you to file the claim. Upon receipt, Delta Dental will verify eligibility and make payment for one-half of the predetermined benefit amount, subject to the lifetime maximum orthodontia benefit for the coverage option you were enrolled in at the time of appliance banding.

A second Estimate of Benefits will be issued at the time of payment.

After six months of ongoing treatment, the provider should file the claim for remaining benefits by submitting the second Estimate of Benefits with the provider's signature to Delta Dental. An out-of-network provider may require you to file the claim. Upon receipt, Delta Dental will verify eligibility and, if the patient is still covered under the Delta Dental coverage options, make payment for the second half of the estimated benefit amount, subject to the lifetime maximum orthodontia benefits.

Delta Dental will pay network providers directly. Delta Dental will pay you directly for services rendered by out-of-network providers. You will be responsible for paying your out-of-network provider.

Treatment in progress when coverage becomes effective
If orthodontia treatment is already in progress when you first enroll in a Delta Dental coverage option, the following information should be submitted to Delta Dental to determine if benefits are available:

• Total treatment cost, including retainers
• Description of the treatment, including procedure code
• Estimated length of active treatment (total time, not just time remaining)
• Date the appliances were installed
• Provider's signature and date

After review and approval by Delta Dental, benefits will be prorated based on the coverage option you were enrolled in at the time of appliance banding. Coverage will also be prorated based on the number of months of active treatment remaining. For adults, prorated orthodontia benefits are only available for banding after January 1, 2008.

Orthodontia benefits paid under the former Wachovia Dental Program will be applied to the lifetime maximum benefit under the Wells Fargo dental plan. No additional benefit is payable by changing coverage option from the Standard to Enhanced option or vice versa.
Coordination of benefits

The Delta Dental coverage options include a coordination of benefits provision called “nonduplication of benefits.” This means that if you or your eligible dependents are covered by another dental plan and the Delta Dental coverage option is the secondary payer, then the Delta Dental coverage option will pay the difference of the amount it would have paid if it had been the primary plan minus the amount paid by your primary plan. For example, if the Delta Dental coverage option would have paid $400 as the primary plan, and your primary plan pays $400 or more, then the Delta Dental coverage option will pay nothing.

Delta Dental's calculation of what it would pay if Delta Dental’s coverage had been primary also considers the annual maximum benefit available at the time of your claim. For example, if you have $500 left of your annual maximum benefit with Delta Dental and the primary plan paid $500 or more for a claim, the Delta Dental coverage option would pay nothing for that claim.

Also, there is no coordination of benefits between benefit options under the Health Plan. Benefits will not be paid from more than one Health Plan benefit option for the same services. For example, you cannot receive benefits under the Health Plan from both a dental plan option and a medical plan option for the same services.

The following rules determine the primary plan:

- The plan with no coordination of benefits provision is primary.
- If both plans have a coordination of benefits provision:
  - For employees and their spouses or domestic partners, the plan covering the patient as an employee (rather than a dependent) is primary.
  - For covered children, the plan of the parent whose birthday falls earlier in the year is primary.
  - For children of divorced or separated parents, plans pay in this order, unless a court decree stipulates otherwise:
    1. The plan of the parent who has custody of the child.
    2. The plan of the spouse or domestic partner of the parent who has custody of the child.
    3. The plan of the parent who does not have custody of the child.

Questions about claim determinations

If you have a question or concern about a claim processed by Delta Dental, you may call Delta Dental's member services. In the event your claim is denied (in whole or in part), you may also file a formal written appeal under the terms of the Health Plan. Please note that if you call Delta Dental, your call will not be considered a formal appeal under the terms of the Health Plan. A formal written appeal must be filed with Delta Dental within 180 days of the date your claim is denied regardless of any verbal discussions that have occurred regarding your claim.

For member services information, see the “Contacts” section on page 3-2.

Complete information on appeals is provided in “Appendix A: Claims and Appeals.”

Right of recovery

The dental benefit option is part of the Wells Fargo & Company Health Plan (the Health Plan). The Health Plan has the right to recover benefits it has paid on your or your dependent’s behalf that were: (a) made in error, (b) due to a mistake in fact, (c) paid before you meet the annual deductible, (d) caused by the act or omission of another party, (e) covered by no-fault or employers’ liability laws, (f) available or required to be furnished by or through national or state governments or their agencies, or (g) the result of injury sustained on the property of a third party. Benefits paid because you, your dependent, or provider misrepresented facts are also subject to recovery. Right of recovery may be pursued by claims reprocessing, by notification of overpayment, or through the subrogation process.

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
**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.

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.

**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.

**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 subrogation 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.”
Chapter 4

Vision Plan

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<th>Vision Service Plan (VSP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-877-861-8352</td>
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<tr>
<td></td>
<td>wf.vspforme.com</td>
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<tr>
<td></td>
<td>Member ID is your Employee ID preceded by zeros to equal an 11-digit number.</td>
</tr>
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| Information about vision benefit provisions | Teamworks |

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<th>Information about enrollment</th>
<th>Team Member Care (formerly known as the HR Service Center)</th>
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<td></td>
<td>1-877-HRWELLS (1-877-479-3557), option 2</td>
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<tr>
<td></td>
<td>Team Member Care accepts relay service calls. TDD/TTY users may call 1-800-988-0161.</td>
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</table>

| Information about premiums | Check your enrollment materials, or go to Teamworks. |
The information in this chapter — along with that in “Chapter 1: An Introduction to Your Benefits,” “Appendix A: Claims and Appeals,” “Appendix B: Important Notifications and Disclosures,” “Appendix D: Leaves of Absence and Your Benefits,” and “Appendix E: Continuing Coverage Under COBRA” — constitutes the Summary Plan Description (SPD) for the vision benefit option available under the Wells Fargo & Company Health Plan (the Health Plan). The vision benefit option is also referred to as the vision plan.

The basics

General information
The Vision Service Plan (VSP) is the vision benefit option under the Wells Fargo & Company Health Plan. The Wells Fargo & Company Health Plan is a group health plan and is classified as a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

You must be enrolled in the vision plan on the date of service to receive benefits.

The vision plan covers periodic professional eye exams for you and your covered dependents. The exam includes an analysis of the visual functions, and you may receive a prescription for corrective lenses if indicated.

If you are enrolled in the vision plan, you agree to authorize your provider to give VSP access to required information about your care. Your failure to provide this authorization or any requested information may result in denial of your claim. VSP may require this information to process claims, to conduct quality improvement and utilization review activities, or for other health plan activities, as permitted by law. VSP may release the information, if you authorize VSP to do so, or if state or federal law permits or allows release without your authorization.

Who’s eligible
Regular and part-time Wells Fargo team members are eligible to enroll in the vision plan. If you are enrolled as an eligible team member, you may also cover your eligible dependents including your spouse or domestic partner. However, you may not be covered under the vision plan as both a team member and spouse or domestic partner, or a team member and a dependent child at the same time. Also, a dependent can only be covered under one team member. Detailed eligibility requirements are described in the “Who’s eligible to enroll” section in “Chapter 1: An Introduction to Your Benefits.”

How to enroll and when coverage begins
Refer to the “How to enroll” section in “Chapter 1: An Introduction to Your Benefits” for the time frame and process for enrollment. After you have enrolled, coverage will begin as described in the “When coverage begins” section in “Chapter 1: An Introduction to Your Benefits.”

Changing or canceling coverage
You may make changes to your enrollment election during the Annual Benefits Enrollment period or if you experience certain Qualified Events during the year. For more information on making enrollment election changes, refer to the “Changing coverage” section in “Chapter 1: An Introduction to Your Benefits.”

When coverage ends
Vision coverage for you or any enrolled dependents ends as described in the “When coverage ends” section in “Chapter 1: An Introduction to Your Benefits.”

Cost
You contribute to pay for the cost of vision coverage. For more information, refer to the “Cost and funding” section in “Chapter 1: An Introduction to Your Benefits.”

Claims administrator
The vision plan is self-insured, and VSP is the claims administrator providing administrative claims services. VSP is the named claims and appeals fiduciary for the vision plan and has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the vision plan.

How the vision plan works
The vision plan uses VSP’s Choice Network, which contracts with a nationwide network of private practice optometrists and ophthalmologists, many of whom are located in retail settings. You will generally pay less out of pocket if you use a network provider rather than an out-of-network provider.

You will receive an ID card from VSP. You may also print a personalized ID card from wf.vspforme.com.

It’s between you and your provider to determine the treatment or procedures you’ll receive. The provisions of the vision plan control what, if any, benefits are available for the services you receive.
Using a network provider
For information about network providers, check wf.vspforme.com or call 1-877-861-8352. Network providers are available in all 50 states, the District of Columbia, and Puerto Rico.

If you use a network provider, identify yourself as a VSP participant when scheduling an appointment. You will pay a copay for covered exams and eyewear that fall within the vision plan’s allowance. You will not need to file a claim for reimbursement because the provider bills VSP. Network benefits will be provided as shown in the “Your vision plan benefits and costs at a glance” table on page 4-5, subject to the provisions stated within this chapter of the Benefits Book.

Using a retail chain affiliate
A retail chain affiliate is not contracted as a VSP network provider, but has agreed to bill VSP directly and provide discounted rates for VSP members for available services. It’s important to note that not all listed services are available from some retail chain affiliates. For information about retail chain affiliates 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 six 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. A calendar year is the period January 1 through the following December 31.

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<tr>
<th>Plan features</th>
<th>Network benefits*</th>
<th>Out-of-network benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exams</td>
<td>$10 copay.</td>
<td>Vision plan pays up to $45.</td>
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<tr>
<td>(once every calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td>$15 copay.</td>
<td>Vision plan pays up to $45.</td>
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<tr>
<td>(once every calendar year)</td>
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<td></td>
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<tr>
<td>Including polycarbonate lenses for enrolled dependent children</td>
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<td></td>
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<tr>
<td>• Single vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bifocal</td>
<td>$15 copay.</td>
<td>Vision plan pays up to $65.</td>
</tr>
<tr>
<td>• Trifocal</td>
<td>$15 copay.</td>
<td>Vision plan pays up to $85.</td>
</tr>
<tr>
<td>• Lenticular</td>
<td>$15 copay.</td>
<td>Vision plan pays up to $125.</td>
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<tr>
<td>Frames</td>
<td>Vision plan pays $175 toward a frame of your choice.</td>
<td>Vision plan pays up to $50.</td>
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<td>(once every calendar year)</td>
<td></td>
<td></td>
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<tr>
<td>Contact lenses</td>
<td>Vision plan pays $175 toward contact lenses. (Includes evaluation and fitting services.)</td>
<td>Vision plan pays up to $175.</td>
</tr>
<tr>
<td>(once every calendar year, in lieu of glasses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Elective</td>
<td>Vision plan pays $175 toward contact lenses. (Includes evaluation and fitting services.)</td>
<td>Vision plan pays up to $175.</td>
</tr>
<tr>
<td>• Medically necessary</td>
<td>Vision plan pays up to $190.</td>
<td></td>
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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.

<table>
<thead>
<tr>
<th>Plan features</th>
<th>Network benefits*</th>
<th>Out-of-network benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Eye examination</td>
<td>$20 copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>• Special ophthalmological services</td>
<td>Covered in full.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

* Not all listed services are available from some retail chain affiliates. Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit wf.vspforme.com for details.

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 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:
- 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 have a $15 copay. 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 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 when you receive frames from a VSP network provider. You must pay any additional cost if you select a frame that exceeds the vision plan allowance. When using a VSP network provider, you may ask to see frames that would be fully paid by the vision plan allowance.

Refer to the “Your vision plan benefits and costs at a glance” table on page 4-5 for out-of-network benefits, and to the “What is not covered” section starting on page 4-7 for exclusions.

Low vision services
The low vision benefit provides special aid for people who have severe visual problems and may be referred to as “partially sighted.” Low vision services and associated eyewear are subject to certain limitations. Therefore, before receiving services, contact VSP for more information to ensure that the services you need are covered under the vision plan.

You must pay 25% of the cost of any approved low vision program. This benefit has a maximum of $1,000 (excluding copays) every two calendar years. The maximum includes supplementary testing.

Refer to the “What is not covered” section starting on page 4-7.
Diabetic Eyecare Plus Program
The Diabetic Eyecare Plus Program (DEP Plus) provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma, or age-related macular degeneration when covered services are received from a VSP network provider. A current list of these procedures will be made available to you upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service. Plan benefits under this program are available to those diagnosed with type 1 or type 2 diabetes or specific ophthalmological conditions.

Examples of symptoms that may result in your seeking services under DEP Plus may include, but are not limited to:
- Blurry vision
- Trouble focusing
- Transient loss of vision
- “Floating” spots

Examples of conditions that may require management under DEP Plus may include, but are not limited to:
- Diabetic retinopathy
- Rubeosis
- Diabetic macular edema

Refer to the “Your vision plan benefits and costs at a glance” table on page 4-5 for information about what you will pay and to the “What is not covered” section starting on this page for exclusions.

Service frequency
Exams, eyeglass lenses or contact lenses, and eyeglass frames are covered once every calendar year. 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 six months from the date of service when you choose an out-of-network provider
- Cosmetic options, including:
  - Antireflective coating
  - Blended lenses
  - Color coating
  - Cosmetic lenses (plano — prescription strength of less than ±0.50)
  - Laminated lenses
  - Mirror coating
  - Optional cosmetic processes
  - Oversize lenses
  - Photochromic or tinted lenses other than Pink #1 or #2
  - Progressive multifocal lenses
  - Scratch coating
  - UV (ultraviolet)-protected lenses
- Frame charges in excess of the vision plan allowance
- Laser vision surgery
- Local, state, and/or federal taxes, except where VSP is required by law to pay
- Medical or surgical treatment of the eyes
- Orthoptics or vision training and any associated supplemental testing
- Polycarbonate lenses for adults
- Replacement of lenses and frames furnished under the vision plan that are lost or broken
- Services or materials not indicated as covered

Chapter 4: Vision Plan
• Surgery of any type, and any pre- or post-operative services
• Two pairs of eyeglasses instead of bifocals
In addition, the following are not covered under DEP Plus:
• Services and materials not specifically included as plan benefits
• Frames, lenses, contact lenses, or any other ophthalmic materials
• Treatment for any pathological conditions
• Insulin or any medications or supplies of any type

Coordination of benefits
The vision plan is always primary over other vision plans for the covered team member.

When a team member and his or her 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 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 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 or retail chain affiliate
The VSP network or retail chain affiliate 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 or retail chain affiliate will file claims with VSP. Network providers and retail chain affiliates must file claims with VSP within six months of the date of service. VSP will pay your network provider or retail chain affiliate 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 or retail chain affiliate is required to write off as a result of his or her 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 six months of the date of service.

You must file the claim using VSP’s claim form. For a copy of the claim form, visit wf.vspforme.com or call 1-877-861-8352.

File the claim form, along with the itemized receipt, within six months of the date of service to:

VSP
PO Box 385018
Birmingham, AL 35238

VSP will reimburse you for out-of-pocket costs, up to the amounts stated in the “Your vision plan benefits and costs at a glance” table on page 4-5, provided that you were covered at the time services were received. You are responsible for all charges not covered or reimbursed by VSP.

More information on claims is provided in “Appendix A: Claims and Appeals.”

Claim denials and appeals
If you have a question or concern about a claim processed by VSP, you may call VSP at 1-877-861-8352. In the event that your claim is denied (in whole or in part), you may also file a formal written appeal under the terms of the Health Plan. Please note that if you call VSP, your call will not be considered a formal appeal under the terms of the Health Plan. A formal written appeal must be filed with VSP within 180 days of the date your claim is denied regardless of any verbal discussions that have occurred regarding your claim.

Complete information on appeals is provided in “Appendix A: Claims and Appeals.”
Right of recovery

The vision benefit option is part of the Wells Fargo & Company Health Plan (the Health Plan). The Health Plan has the right to recover benefits it has paid on your or your dependent’s behalf that were: (a) made in error, (b) due to a mistake in fact, (c) caused by the act or omission of another party, (d) covered by no-fault or employers’ liability laws, (e) available or required to be furnished by or through national or state governments or their agencies, or (f) the result of injury sustained on the property of a third party. Benefits paid because you, your dependent, or provider misrepresented facts are also subject to recovery. Right of recovery may be pursued by claims reprocessing, by notification of overpayment, or through the subrogation process.

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

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.

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.

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.

**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 subrogation 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.”
## 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

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Teamworks |
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<tr>
<td>To email claims</td>
<td><a href="mailto:paymeback@wageworksclaims.com">paymeback@wageworksclaims.com</a></td>
</tr>
<tr>
<td>To fax claim forms toll-free</td>
<td>1-877-353-9236</td>
</tr>
</tbody>
</table>
| To file claims online, view account information and access account activity and status, or find forms | https://www.wageworks.com  
Access from Teamworks. |
| Information about enrollment | Team Member Care (formerly known as the HR Service Center)  
1-877-HRWELLS (1-877-479-3557), option 2  
Team Member Care accepts relay service calls. TDD/TTY users may call 1-800-988-0161. |
The information in this chapter — along with “Chapter 1: An Introduction to Your Benefits,” “Appendix A: Claims and Appeals,” “Appendix B: Important Notifications and Disclosures,” “Appendix D: Leaves of Absence and Your Benefits,” and “Appendix E: Continuing Coverage Under COBRA” — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Health Care Flexible Spending Account Plan (the Health Care FSA Plan). The Health Care FSA Plan is an employee benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The basics

Introduction

The Health Care FSA Plan is sponsored by Wells Fargo & Company and is administered by WageWorks. The Health Care FSA Plan includes two FSA options — the Full-Purpose Health Care Flexible Spending Account (Full-Purpose Health Care FSA) and the Limited Dental/Vision Flexible Spending Account (Limited Dental/Vision FSA), as described in this chapter. Each allows you to set money aside on a before-tax basis to pay for eligible expenses not reimbursed by another source. It is important to note that the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA options have unique and separate enrollment requirements and vary in the types of expenses that can be reimbursed. Your decision to participate in these voluntary accounts should be based on your needs and personal situation. It is important that you understand the advantages and limitations of the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA before you decide whether to participate.

You may contribute from $130 to $2,600 annually to either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, subject to limitations imposed by applicable law and IRS guidance.

The information provided in this chapter is not intended to provide tax advice for any individual’s specific situation. If you have any questions regarding the tax implications of your specific situation — including questions about whether taking health care deductions on your tax returns or enrolling in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA is more favorable to you — please consult your tax advisor.

Note: The Health Care FSA is subject to the Employee Retirement Income Security Act of 1974 (ERISA), which is a federal law that establishes minimum standards for the operation of pension, health, and other welfare benefit plans. ERISA’s fiduciary duty rules, including the exclusive benefit rule, govern how a company may legally use participant forfeitures. The exclusive benefit rule provides that plan assets, including participant forfeitures, cannot be used for the benefit of the employer and must be used for the exclusive purpose of providing benefits to plan participants and beneficiaries, or dependents, and defraying reasonable plan administration expenses. Consistent with the requirements under ERISA, participant forfeitures are used to pay for administrative expenses of the Health Care FSA as well as to provide benefits to plan participants and their dependents.

Any balance remaining in your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA after eligible expenses have been submitted and reimbursed by the filing deadline will be forfeited and cannot be rolled over or paid out to you. For more information on the claims filing deadline, see the “Claims filing time frame” section on page 5-19.

Claims administrator

WageWorks, Inc. (WageWorks) is the claims administrator and processes requests for reimbursement from the applicable Full-Purpose Health Care FSA and the Limited Dental/Vision FSA. WageWorks is the named claims and appeals fiduciary and has the sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the Health Care FSA Plan and respective FSA options.

Reimbursements

Each FSA is a bookkeeping account established to keep track of your contributions and reimbursements. Except as required by law, amounts credited to the applicable FSA remain the property of Wells Fargo & Company until reimbursed to the participant. Although this chapter refers to payroll deductions and contributions that are set aside, these deductions and contributions reflect pay reductions that you authorize with the understanding that all such deductions and contributions are held as, and reimbursements paid from, Wells Fargo & Company's general assets. No specific assets are set aside or otherwise segregated from Wells Fargo & Company's general assets for reimbursements.
Health Care FSA Plan options

You may only enroll in one of these options as indicated below.

The Full-Purpose Health Care FSA

The Full-Purpose Health Care FSA allows you to be reimbursed for eligible medical, dental, and vision expenses (for example, copayments, orthodontia, eyeglasses, and prescribed medications for you or your eligible dependents) that are not reimbursed by another source. For more information about eligible expenses under the Full-Purpose Health Care FSA, go to https://www.wageworks.com.

- You may elect the Full-Purpose Health Care FSA only if you meet one of the following criteria:
  - You are enrolled in the HRA-Based Medical Plan (including Out of Area).
  - You are enrolled in an HMO — Kaiser or the POS Kaiser Added Choice — Hawaii option.
  - You are enrolled in the UnitedHealthcare Global — Expatriate Insurance plan (for expatriates only).
  - You do not elect other medical coverage sponsored by Wells Fargo.

- You cannot elect the Full-Purpose Health Care FSA if you are enrolled in one of the high-deductible health plans: the HSA-Based Medical Plan – Gold (including Out of Area), the HSA-Based Medical Plan – Silver (including Out of Area), or an HDHP — Kaiser medical plan.

- It is your responsibility to manage your balance and allow ample time for all transactions (including Card transactions, Card Use Verification Forms, and claims and expense documentation) to clear before December 31. For example, a card swipe on December 31, 2016, may not clear until early 2017. You may also want to refrain from submitting your card number on invoices during the last week of December as some providers may not process it until early 2017. Keep in mind that reimbursement requests can be used to offset outstanding Card use verifications, so make sure all Card Use Verification Forms are submitted in a timely manner.

Note: The information in this section regarding HSA contributions is not part of the Health Care FSA Plan Summary Plan Description and is provided for informational purposes only. HSAs are individually owned accounts and are not subject to ERISA.
The Limited Dental/Vision FSA

The Limited Dental/Vision FSA allows you to be reimbursed for only eligible dental or vision expenses that are not reimbursed by another source. **Medical and prescription drug expenses are not eligible for reimbursement under the Limited Dental/Vision FSA.** For more information about eligible expenses under the Limited Dental/Vision FSA, go to https://www.wageworks.com.

- You may elect the Limited Dental/Vision FSA only if you enroll in one of the high-deductible health plans: the HSA-Based Medical Plan – Gold (including Out of Area), the HSA-Based Medical Plan – Silver (including Out of Area), or an HDHP — Kaiser medical plan.

- You cannot elect the Limited Dental/Vision FSA if you enroll in the HRA-Based Medical Plan (including Out of Area), an HMO — Kaiser option or the POS Kaiser Added Choice — Hawaii option, the UnitedHealthcare Global — Expatriate Insurance plan (for expatriates only), or if you waive Wells Fargo-sponsored medical coverage.

- **Important information about health savings account (HSA) eligibility if you have a remaining balance in a Limited Dental/Vision FSA during the grace period,** which runs from January 1 through March 15. If you are currently enrolled in the Limited Dental/Vision FSA, have a remaining balance as of December 31 in your Limited Dental/Vision FSA, and continue your enrollment in one of the high-deductible health plans next year, you may make contributions to your HSA for the new year starting in January of that year. There is no delay in making HSA contributions because you have a remaining balance in the Limited Dental/Vision FSA. The information in this section regarding HSA contributions is not part of the Health Care FSA Plan Summary Plan Description and is provided for informational purposes only. HSAs are individually owned accounts and are not subject to ERISA.
Who’s eligible

You are eligible to enroll in the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA if you are a regular or part-time team member as described in “Chapter 1: An Introduction to Your Benefits.”

Note: If you are enrolled in one of the high-deductible health plans: the HSA-Based Medical Plan – Gold (including Out of Area), the HSA-Based Medical Plan – Silver (including Out of Area), or an HDHP — Kaiser medical plan, the only option that you may elect is the Limited Dental/Vision FSA. For more information on enrollment requirements for these two options, see the “Health Care FSA Plan options” section starting on page 5-4.

Some rules to know

Your contributions to, and reimbursements from, the Full-Purpose Health Care FSA or Limited Dental/Vision FSA are designed to qualify for favorable tax treatment by the IRS. In exchange for these potential tax advantages, the IRS imposes strict rules about how you may use your FSA. Before enrolling, consider the rules described below and the rest of the information in this chapter. Please note the information provided in this chapter is not intended to provide tax advice for any individual’s specific situation. If you have any questions regarding the tax implications surrounding your specific situation, please consult with your own tax advisor.

Note: For the purposes of the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA, the plan year is the same as a calendar year, beginning on January 1 and ending the following December 31.

Full-Purpose Health Care FSA rules

In addition to the information noted below, refer to the “Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA” section starting on this page, the “Using the Card with the Full-Purpose Health Care FSA” section starting on page 5-14, and “The Full-Purpose Health Care FSA” section on page 5-4 for other applicable rules.

• When you enroll in the Full-Purpose Health Care FSA, you will automatically receive a WageWorks FSA Card (Card). Your Card can only be used at:
  – Medical, dental, and vision health care providers
  – General merchandise stores that have an inventory system that meets IRS requirements
  – Select pharmacies

• As a result of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, “the Act”), certain over-the-counter drugs, medicines, and biologicals are only eligible for reimbursement under the Full-Purpose Health Care FSA with a physician’s prescription. This means that most IRS-approved stores and pharmacies do not allow the use of the Card for over-the-counter drugs. If your Card is used and accepted for the purchase of over-the-counter drugs, you will be required to submit an itemized receipt and physician’s prescription. Please refer to the “Eligible (or qualified) expenses” section on page 5-18 for a list of items requiring a prescription.

Limited Dental/Vision FSA rules

In addition to the information noted below, refer to the “Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA” section starting on this page, the “Using the Card with the Limited Dental/Vision FSA” section on page 5-16, and “The Limited Dental/Vision FSA” section on page 5-5 for other applicable rules.

• When you enroll in a Limited Dental/Vision FSA, you will automatically receive a WageWorks FSA Card (Card). Your Card can only be used at:
  – Dental providers
  – Vision providers

• Medical and prescription drug expenses (including over-the-counter drugs even if you have a prescription) are not eligible for reimbursement under the Limited Dental/Vision FSA.

Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA

• You must use the money for eligible expenses that are incurred: (1) in the same year you contribute it or during the grace period described below and (2) while you are a participant. You cannot be reimbursed for expenses incurred before your participation begins or after your participation ends.

• If, as the result of a Qualified Event or termination of employment, you terminate your participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, expenses incurred after you are no longer a participant are not eligible for reimbursement, unless you enroll for COBRA continuation coverage to extend your participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA.
• If you are enrolled in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA on December 31 of a plan year and have not exhausted your balance, you qualify for a grace period — January 1 through March 15 of the year following the plan year. This grace period extends the time period during which you can incur eligible expenses. Eligible expenses incurred during the grace period that are eligible for reimbursement will be reimbursed from the prior plan year’s balance until that balance is exhausted. If you are also participating in the same FSA option during the plan year in which the expenses are incurred, then any eligible expenses that are not paid from the prior plan year’s balance may be eligible to be paid from the current plan year’s balance. Please note: Card use must occur prior to the March 15 grace period deadline in order to apply to the prior year. Any Card use after the March 15 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, 2016, you incur $100 worth of eligible expenses on January 15, 2017, and submit a request for reimbursement on January 30, 2017. At that time, you have a $50 balance still remaining in your 2016 Full-Purpose Health Care FSA. Accordingly, $50 of your $100 eligible expenses will be reimbursed to you from your 2016 account and the remaining $50 may be eligible to be reimbursed from your 2017 account if you have elected the Full-Purpose Health Care FSA for 2017.

• An eligible expense is incurred when the service is received, not when payment is made. For example, if you receive the service on May 10 but pay for services in June after receiving a billing statement, the expense is incurred on May 10. Similarly if you prepay for services, the expense is not incurred until the service is actually received.

• You must submit completed claims to WageWorks and resolve all outstanding WageWorks FSA Card (Card) use verification requests by April 30 of the following plan year. The claim must include proper expense documentation for eligible expenses incurred during the plan year or during the applicable grace period. To ensure that your claims are complete by this date, submit your initial claims early in case you are asked for additional information or are missing any items. Claims, WageWorks FSA Card (Card) use verification requests, 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 WageWorks (for example, documentation from your provider that contains the provider’s name, the patient’s name, the date of service, description of product or service, and the amount to be reimbursed). An Explanation of Benefits (EOB) from your health carrier generally is an acceptable form of documentation.

• With either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, Card transactions may be automatically verified. If your Card transaction is automatically verified, you will generally not have to submit a receipt to WageWorks after the transaction. You are, however, required to keep each itemized receipt for tax purposes in the event it is needed for verification. See the “Using your WageWorks FSA Card” section on page 5-13 for more information.

• 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.

• After you enroll in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, you may not increase or decrease your elected contributions unless you have a Full-Purpose Health Care FSA- or Limited Dental/Vision FSA-related Qualified Event. For more information, refer to the “Qualified Events” table in “Chapter 1: An Introduction to Your Benefits.”

• No deduction will be made if your available pay is less than your applicable FSA per-pay-period contributions. If this happens, missed contributions will be made up by increasing your per-pay-period contribution amount for the rest of the plan year, beginning with the next payroll period in which available pay allows for this deduction.
• If you experience a Qualified Event and you increase your elected contributions, claims against the increased elected contribution amount must be incurred on, or after, the effective date of the newly elected annual contribution amount. Your new per-pay-period contribution amount will be calculated by subtracting your year-to-date contributions from your newly elected annual contribution amount and dividing the difference by the number of pay periods remaining for the plan year.

For example:
- Your original annual contribution for the Full-Purpose Health Care FSA option is $1,000 elected during Annual Benefits Enrollment.
- Assuming 26 pay periods per plan year results in a $38.46 contribution per pay period.
- A Qualified Event occurs on September 4.
- You call Team Member Care (formerly known as the HR Service Center) on September 10, provide complete information about the Qualified Event, and elect to increase your annual contribution to $2,600 for the plan year.
- The effective date for the increased election is October 1. Assuming there have already been 20 pay periods under your prior election, your per-pay-period contributions will be increased from $38.46 to $305.13 for the remainder of the plan year ($2,600 minus $769.23 collected in the prior 20 pay periods leaves $1,830.77 to be divided between the remaining six pay periods).
- You may only be reimbursed up to $1,000 for expenses incurred before October 1. However, if you have not incurred $1,000 worth of expenses by October 1, you can continue to incur eligible expenses during the remainder of the plan year and the applicable grace period. Eligible expenses incurred from October 1 through the end of the plan year (and during the applicable grace period) cannot exceed the difference between your increased election of $2,600 less the amount of any reimbursements for eligible expenses incurred prior to October 1.
- If you experience a Qualified Event and you elect to decrease your annual contributions but want to continue your participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, you may not elect to decrease your annual contribution below the amount you have already contributed up to the date the election change is effective. Your reduced annual contribution is also subject to the minimum per-pay-period contribution of $5.00 to continue your participation. Continuing your participation allows you to continue to file claims for eligible expenses incurred after the effective date of the change. If you experience a Qualified Event and you elect to decrease your annual contribution for expenses incurred after your election change is effective, your annual claims reimbursement is limited to the new reduced amount minus any prior reimbursements. Your new per-pay-period contributions will be calculated by subtracting your year-to-date contributions from your new annual contribution amount and dividing the difference by the number of pay periods remaining for the plan year.

For example:
- Your original annual contribution for the Full-Purpose Health Care FSA is $2,000 elected during Annual Benefits Enrollment.
- Assuming 26 pay periods per plan year results in a $76.92 contribution per pay period.
- A Qualified Event occurs on September 4.
- You call Team Member Care (formerly known as the HR Service Center) on September 10 and provide complete information about the Qualified Event, allowing you to elect to decrease your annual contribution to $1,850 for the plan year.
- The effective date for the decreased annual contribution election is October 1. Assuming there have already been 20 pay periods under your prior election, your per-pay-period contributions will be decreased from $76.92 to $51.92 for the remainder of the plan year ($1,850 minus $1,538.46 collected in the prior 20 pay periods leaves $311.54 to be divided between the remaining six pay periods). For expenses incurred after October 1, you may only be reimbursed up to $1,850 minus any prior reimbursements.

• Midyear election changes from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA or vice versa are not allowed, even if you experience an applicable special enrollment right or Qualified Event that allows you to elect a different medical benefit option during the year. Refer to the “Qualified Events” table in “Chapter 1: An Introduction to Your Benefits.”

For example:
- During Annual Benefits Enrollment, you enroll in the HRA-Based Medical Plan (including Out of Area) and elect to contribute to the Full-Purpose Health Care FSA.
You get married midyear, and due to the special enrollment right, you add your new spouse to your medical coverage and you change your medical benefit plan from the HRA-Based Medical Plan (including Out of Area) to one of the high-deductible health plans.

You cannot change from the Full-Purpose Health Care FSA to the Limited Dental/Vision FSA due to this midyear special enrollment right.

You can either elect to increase or maintain your current election in the Full-Purpose Health Care FSA. In this example, you are unable to elect to decrease or drop your current election in the Full-Purpose Health Care FSA.

You can continue to use your Full-Purpose Health Care FSA while your participation continues.

Neither you nor Wells Fargo can make contributions toward your health savings account (including earned health and wellness dollars) while you are a participant in the Full-Purpose Health Care FSA. This means that if you have a midyear change to enroll in one of the high-deductible health plans but you continue to be enrolled in the Full-Purpose Health Care FSA, neither you nor Wells Fargo can contribute to an HSA.

If you have a midyear special enrollment right or Qualified Event allowing you to enroll in one of the high-deductible health plans, in order to be able to make contributions to a health savings account, you must make a corresponding election to drop your Full-Purpose Health Care FSA if allowed per the “Qualified Events” table in “Chapter 1: An Introduction to Your Benefits.” If you do not, or if you are not permitted to drop your Full-Purpose Health Care FSA in connection with the Qualified Event or special enrollment right, contributions cannot be made to your health savings account. Not all Qualified Events permit you to drop your Full-Purpose Health Care FSA. See the example in the previous bullet.

If you are rehired or return to a benefits-eligible position within the same year, and you elect to participate in either the Full-Purpose Health Care FSA or Limited Dental/Vision FSA both prior to termination or loss of benefits eligibility and after your rehire or return to benefits eligibility, each period is separate and distinct. In addition, unused funds from your prior period cannot be used for expenses incurred after your rehire. You cannot contribute more than $2,600 for the entire plan year between the combined two periods of employment. If you also elected COBRA continuation coverage for your FSA during your interim employment periods, these contributions will also be included in the combined total, which cannot exceed $2,600 for the entire plan year.

For example:

Your original annual contribution for the Full-Purpose Health Care FSA is $1,500 elected during Annual Benefits Enrollment with a January 1 effective date (assuming there are 26 pay periods in the year, $1,500 divided by 26 = $57.69 per-pay-period contributions).

Employment with Wells Fargo is terminated on March 15.

You can request reimbursement for eligible expenses up to the full $1,500 elected amount, as long as those expenses are incurred prior to March 31.

You are rehired on August 15 with coverage effective October 1 (the first of the month after one full calendar month of service). You are eligible to elect $2,253.85 ($2,600 annual limit minus $346.15 taken in prior payroll deductions). However, you elected a $1,000 Full-Purpose Health Care FSA annual contribution amount upon your rehire (assuming six pay periods remain in the plan year, $1,000 divided by six remaining pay periods = $166.67 per-pay-period contributions).

You may only be reimbursed up to $1,000 for expenses incurred between October 1 and the end of the plan year, including the grace period. Any unused funds from your prior enrollment cannot be used for expenses incurred after your rehire.

When you file your tax returns, you cannot deduct or claim a tax credit for expenses paid by either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA.

Your contributions

If you enroll in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, your before-tax pay will be reduced each pay period by the per-pay-period contribution amount and will be rounded to the nearest penny. Your elected annual contribution will be divided by the number of eligible pay periods in the calendar year. If you enroll midyear because you are newly hired or newly eligible, or experience a Qualified Event, your elected annual contribution will be divided by the number of eligible pay periods remaining in the plan year. See the “Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA” section starting on page 5-6 if you experience a midyear Qualified Event that affects your annual contribution.
You can authorize contributions in any amount with a:
• Minimum of $130 per plan year or $5.00 per pay period
• Maximum of $2,600 per plan year

The Full-Purpose Health Care FSA and the Limited Dental/Vision FSA are bookkeeping accounts established to keep track of your contributions and reimbursements. Except as otherwise required by law, amounts credited to the respective Full-Purpose Health Care FSA or Limited Dental/Vision FSA option remain the property of Wells Fargo & Company until reimbursed to participants. When you enroll in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA option during the Annual Benefits Enrollment period, Wells Fargo credits your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA with your full annual elected contribution amount on January 1.

For example: If you elect to contribute $1,000 for the year, $1,000 will be available for reimbursement on the first day of January following the Annual Benefits Enrollment period during which the election was made. You can use the full $1,000 for eligible expenses incurred on January 1, the first day of the new plan year. If you are newly hired and enroll in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, Wells Fargo credits your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA with your full annual elected contribution amount on your first day of coverage.

How to enroll

New hire and employment classification change enrollment

If you are eligible, you may enroll in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA by going to the benefits enrollment site on Teamworks, at work or at home, or by calling Team Member Care (formerly known as the HR Service Center) during your designated enrollment period. For more information, see the “How to enroll” section in “Chapter 1: An Introduction to Your Benefits” and the “Health Care FSA Plan options” section starting on page 5-4.

If you enroll during your designated enrollment period, your participation begins on the first of the month following one full calendar month of service in a benefits-eligible position. If you enroll, you must participate for the remainder of the plan year (calendar year) unless you have a Qualified Event that permits dropping coverage. For more information, see the “Changing coverage” section in “Chapter 1: An Introduction to Your Benefits.”

If you do not enroll during your initial designated enrollment period, you cannot elect to participate in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA until the first day of the plan year following the next Annual Benefits Enrollment period, unless you experience an eligible Qualified Event that permits you to make a midyear election. For more information, see the “Changing coverage” and the “Qualified Events” sections in “Chapter 1: An Introduction to Your Benefits.”

Annual Benefits Enrollment

Participation in either the Full-Purpose Health Care FSA or Limited Dental/Vision FSA option does not continue automatically from year to year. You must make an affirmative annual contribution election during each Annual Benefits Enrollment period to participate the following plan year. During the Annual Benefits Enrollment period, you may make a new annual contribution election for the next plan year or choose not to enroll.

Rehire or return to benefits-eligible status

If you are an eligible rehired team member, or you return to benefits-eligible status in the same plan year in which you were previously enrolled, and you want to participate in either the Full-Purpose Health Care FSA or Limited Dental/Vision FSA option, you must reenroll during your designated enrollment period. In addition, your election amount after your rehire or return to benefits-eligible status will be limited to the annual contribution limit minus any Full-Purpose Health Care FSA or Limited Dental/Vision FSA payroll contributions taken prior to your previous same plan year termination or move to benefits-ineligible status so that you do not exceed the applicable contribution limit for the plan year.

For more information about the Full-Purpose Health Care FSA or Limited Dental/Vision FSA after a rehire or return to benefits-eligible status, see the “Health Care FSA Plan options” section starting on page 5-4 and the “Some rules to know” section starting on page 5-6.
Changing participation

Changes are restricted

IRS regulations restrict your ability to change your contributions to the Full-Purpose Health Care FSA or Limited Dental/Vision FSA during the plan year. You cannot change your contribution amount to your Full-Purpose Health Care FSA or Limited Dental/Vision FSA unless you have experienced an applicable Qualified Event.

For more information about Qualified Events, see the “Changing coverage” and “Qualified Events” sections in “Chapter 1: An Introduction to Your Benefits.”

For more information on how a change in contributions, as a result of a Qualified Event, may impact the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, see the “Rules for both the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA” section starting on page 5-6.

Employment classification change

If you begin participating in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA and then change your employment classification to a non-benefits-eligible position, your contributions stop at the end of the month after the change in employment status is processed. You may, however, still submit claims for eligible expenses incurred up to the end of the month of your employment classification change. You may continue participation in the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA under COBRA. For more information, see the “COBRA coverage” section starting on this page.

Leave of absence

For information on contributions during a leave of absence, see “Appendix D: Leaves of Absence and Your Benefits.”

Claims

If you participate in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA, you can claim eligible expenses incurred during your approved leave.

Annual Benefits Enrollment while on leave

If you have elected participation in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA and you are on a leave of absence on January 1 without recognized sources of income replacement, contributions, including any applicable missed contributions for the current plan year, will begin when you return to work in a benefits-eligible position. Your payroll deductions will be adjusted for the rest of the plan year to account for any applicable missed contributions while you were on leave. However, Wells Fargo credits your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA with your full annual elected contribution amount on January 1.

When participation ends

Participation in the Full-Purpose Health Care FSA and the Limited Dental/Vision FSA ends when Wells Fargo stops providing the Health Care FSA Plan* (or applicable option) or on the last day of the month that:

- Your Wells Fargo employment is terminated or you retire.
- You no longer meet the eligibility requirements.
- You cancel participation, as permitted by Health Care FSA Plan provisions.
- You die.

* For more information on the Health Care FSA Plan’s amendment and termination procedures, see the “Future of the plans” section in “Appendix B: Important Notifications and Disclosures.”

Your WageWorks FSA Card is deactivated when your participation ends. You may continue to file claims for eligible expenses incurred before the date your participation ends up until your available account balance is zero or until April 30 of the next calendar year, whichever occurs first. As noted above, eligible expenses are incurred when the service is received and not when you pay the provider.

For example: If you start participating in the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA at the beginning of the plan year and then terminate employment on May 15, your participation will end on May 31 and you may file claims for eligible expenses incurred between January 1 and May 31. You have until April 30 of the next calendar year to submit these claims.

If you have provided fraudulent information regarding the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA option (or otherwise committed fraud with respect to the Full-Purpose Health Care FSA or Limited Dental/Vision FSA), your participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA may be terminated (or you may not be permitted to participate in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA).

COBRA coverage

Team members who are no longer eligible for benefits may choose 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 by check. If you have a large unclaimed
balance, electing COBRA continuation coverage allows you additional time to incur expenses as only expenses incurred while you participate are eligible for reimbursement. Participation can continue until your COBRA eligibility ends or the end of the current plan year, whichever is sooner. Participation will cease if you stop making COBRA payments. If you do stop making COBRA payments, your participation will end before your COBRA eligibility and before the end of the plan year. For more information, see “Appendix E: Continuing Coverage Under COBRA.”

If you die
If you die, your eligible dependents (as defined in the “Eligible dependents” section on page 5-13) or the executor of your estate may continue to file claims for eligible expenses incurred while you were a participant in the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA until your applicable account balance is used up or the final claim deadline, whichever occurs first. 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 by check.

Using the Full-Purpose Health Care FSA and Limited Dental/Vision FSA

General information
The Full-Purpose Health Care FSA allows you to be reimbursed for eligible medical, dental, and vision expenses (for example, copayments, orthodontia, eyeglasses, and prescribed medications for you or your eligible dependents) that are not reimbursed by another source.

The Limited Dental/Vision FSA allows you to be reimbursed only for eligible dental or vision expenses that are not reimbursed by another source. Medical and prescription drug expenses are not eligible for reimbursement under the Limited Dental/Vision FSA.

Using your Full-Purpose Health Care FSA and Limited Dental/Vision FSA dollars

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<tr>
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</table>
Eligible dependents
You can use the Health Care FSAs to be reimbursed for eligible health care expenses for any of the following people:

• Yourself
• Your spouse
• Your domestic partner, only if he or she qualifies as your dependent under the Internal Revenue Code
• Your qualifying child, including adult children up to age 24*
• Your qualifying relative*

* Special rules may allow a dependent’s expense to be eligible for reimbursement under the FSA even when that dependent does not qualify to be claimed as your tax dependent on your tax return form. You should consult with your tax advisor regarding any tax implications.

Using your WageWorks FSA Card
When you enroll in either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA option, you will automatically receive a WageWorks FSA Card (Card). You may receive additional Cards for a spouse or adult-aged (18 or older) eligible dependents by visiting https://www.wageworks.com or by contacting WageWorks customer service, and you must cancel dependent Cards by calling WageWorks customer service when the dependent is no longer eligible. The Card makes it easier to use the amount you've contributed to your Full-Purpose Health Care FSA or Limited Dental/Vision FSA by giving you a convenient way to pay for qualified expenses directly from your FSA.

Cardholders have a Personal Identification Number (PIN), which gives you the option to select “debit” and enter the PIN at the point of sale. You cannot use the PIN for cash access at ATMs or merchants. You are not required to use the PIN and all merchants may not be able to accept PIN transactions. You may continue to select the “credit” option and sign the receipt. Please call 1-877-WageWorks (1-877-924-3967) if you forget your PIN or have additional questions about your PIN.

The dollar limit on your Card will be the amount you elected to contribute to your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA during the Annual Benefits Enrollment period or your initial enrollment period (minus any amounts already reimbursed to you or paid by the Card).

The dollar limit on your Card will also be adjusted to reflect allowed midyear changes to your annual contribution (minus any amounts already reimbursed to you or paid by the Card).

Your Card must be activated before using it to pay for eligible expenses. By activating your Card, you agree to the terms and provisions outlined in the Terms and Conditions of Use included with your Card. Be sure to read the material carefully.

Replacement cards
Call WageWorks at 1-877-924-3967 immediately if your Card is lost or stolen.

Unauthorized transactions
You cannot stop payment to merchants for transactions made through the use of the WageWorks FSA Card. However, if you see any unauthorized transactions, you must contact WageWorks within 60 days of the transaction date. Call WageWorks at 1-877-924-3967 or send your written request to the address below.

WageWorks Card Operations
1050 W. Washington St.
Tempe, AZ 85281

You must provide WageWorks with the following information:

• Your name
• Your Card number
• A description of the error or transaction and why you believe it is an invalid transaction
• The date of the transaction in dispute
• The dollar amount of the transaction in dispute

WageWorks will research your disputed transaction. If WageWorks determines that an error occurred, WageWorks will credit your FSA accordingly. If WageWorks determines no error has occurred, you will receive a written explanation from WageWorks and you agree to settle all disputes about Card transactions with the merchant where the dispute arose.

Card suspensions
If WageWorks is unable to determine that a Card transaction was used for eligible expenses according to IRS regulations, WageWorks will ask you to submit a Card Use Verification Form. If WageWorks 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 year and has not already been reimbursed.
3. Reimbursing the FSA for the amount of the original expense. Reimbursements can be made by personal check, money order, or your personal bank's online bill pay system. In order to make sure that your repayment gets posted to the correct account, make sure that account documentation is included on your check, money order, or online bill pay.

Card suspensions carry over from year to year. If your Card is suspended due to a prior year’s expense, your current year’s expenses cannot be used to offset the prior year’s expense. In addition, while your Card is suspended, Pay Me Back and Pay My Provider are your only options for using your account.

Using the Card with the Full-Purpose Health Care FSA
If you are enrolled in the Full-Purpose Health Care FSA, your Card can be used to pay for qualified out-of-pocket health care expenses at merchants that accept Visa® Cards for out-of-pocket costs, such as:

- Copayments, coinsurance, and deductibles for eligible medical, dental, and vision expenses
- Dental and orthodontic expenses
- Vision expenses and LASIK surgery
- Hospital charges
- Prescription drugs (at time of purchase only)

All stores and most pharmacies selling FSA-eligible items will have to have an inventory system that meets IRS requirements in place for the store to accept the Card. Such systems ensure that you can only use your Card for eligible items. As a result, when you use your Card at a store with such a system, you may not need to submit receipts to WageWorks for verification after the purchase if you are enrolled in the Full-Purpose Health Care FSA. The most current list of stores with inventory systems that meet IRS requirements can be found at sigis.com.

As a result of the Patient Protection and Affordable Care Act effective January 1, 2011, certain over-the-counter drugs are not eligible for reimbursement from the Full-Purpose Health Care FSA without a prescription. This means that stores and pharmacies with an inventory system that meets IRS requirements do not allow the use of the Card for over-the-counter drugs. In order to be reimbursed for expenses for over-the-counter drugs with a prescription, you must pay for the drug out of pocket and submit a WageWorks Pay Me Back claim form with the prescription and the receipt.

If you are enrolled in the Full-Purpose Health Care FSA and you use the Card at a health care provider, and WageWorks is unable to verify your patient out-of-pocket responsibility, WageWorks will require that you submit an itemized receipt or an Explanation of Benefits from your medical, dental, or vision plan to verify your patient out-of-pocket responsibility.

If you are enrolled in the Full-Purpose Health Care FSA and you use the Card at a pharmacy that does not have an inventory system that meets IRS requirements, WageWorks will require that you submit an itemized receipt or the Explanation of Benefits from your medical plan to verify that the transaction was for an eligible health care product or service. If your Card is used and accepted for the purchase of over-the-counter drugs, you will be required to submit an itemized receipt and physician’s prescription.

If WageWorks is unable to determine that a Card transaction was used for eligible health care expenses according to IRS regulations, WageWorks will ask you to submit a Card Use Verification Form. If WageWorks does not receive the form with all required documentation within 90 days of the transaction, your Card will be suspended and the amount will be deducted from your next requested Pay Me Back reimbursement check. For more information on resolving Card suspensions, see the “Card suspensions” section on page 5-13.

It is your responsibility to manage your balance and allow ample time for all transactions (including Card transactions, Card Use Verification Forms, and claims and expense documentation) to clear. Also keep in mind that reimbursement requests can be used to offset outstanding Card use verifications, so make sure all Card Use Verification Forms are submitted in a timely manner. Please see the “Required expense documentation” section on page 5-19 for more information.

Access your account at https://www.wageworks.com regularly to see if you have any Card transactions that need verification. Make sure you page through all Alerts & Messages that pop up when you first access the WageWorks website as they are designed to notify you of Card transactions that require verification. Simply follow the prompts online to respond to the Card use verification request to restore your account to its good standing. Due to the time sensitivity of the Card verification requests, it is strongly recommended that you provide your email address to WageWorks by accessing your account and updating your profile. If you do not provide WageWorks with a valid email address, a single notification will be mailed to you. You will not receive notification in any other way.
Go to WageWorks’ Support Center at https://www.wageworks.com to view the web tutorial to learn more about the Card Use Verification Form and process.

Unverified Card transactions can be resolved as follows:

1. Go to https://www.wageworks.com and download your latest Card Use Verification Form.
2. Print out the prefilled Card Use Verification Form.
3. Review the form for information about how and where to submit your receipts, payments, or both.
4. Complete and sign the form.
5. Submit the form along with a detailed receipt as indicated on the form. For more information, see the “Required expense documentation” section on page 5-19.

For your receipt (or any documentation) to be valid, it must include the following five specific pieces of information required by the IRS:

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

After WageWorks receives your Card Use Verification Form and required documentation, if you have a valid email address on file you will receive an automatic email notification when your form has been processed, and if you do not have a valid email on file you will receive an Explanation of Benefits by mail when your form has been processed. If denied, you will be advised of the denial reason, such as ineligible expense.

When using your Card during the grace period (January 1 to March 15), the Card will automatically use your previous year’s funds first if any funds remain. In addition, Card use must occur prior to the March 15 grace period deadline in order to apply to the prior year. Any Card use after the March 15 grace period deadline will apply to the current year and cannot be used to pay for expenses incurred in the prior year. Please keep in mind that if you have any unreimbursed claims to submit for the previous year, you must submit these claims before using your Card during the grace period. Otherwise, if you use your Card for claims incurred during the grace period, you may not have sufficient funds left in your previous year’s account to be reimbursed for claims incurred in the previous year. If you do not have any funds remaining from the previous year or were not enrolled in the previous year, the Card will automatically deduct funds from the available balance of your current year’s Full-Purpose Health Care FSA. Please refer to the “Important note” on page 5-17 in the “Using the Card with the Limited Dental/Vision FSA” section starting on the next page regarding grace period funds if you are enrolled in the Full-Purpose Health Care FSA during the current year and elect the Limited Dental/Vision FSA in the subsequent year.

When using your Card, note the following:

- Your Card can only be used to pay exact amounts you owe for qualified Full-Purpose Health Care FSA expenses. If your purchase includes nonqualified expenses, you must pay for those items separately with another form of payment and you will not be able to manually claim these expenses later.
- If your qualified Full-Purpose Health Care FSA items are not purchased with your Card, you must submit a claim with a copy of your valid receipt (or other valid documentation such as an Explanation of Benefits) to be reimbursed. For more information, see the “Using the Full-Purpose Health Care FSA and Limited Dental/Vision FSA” section on page 5-12.
- For mail-order prescriptions under the Full-Purpose Health Care FSA, you may enter the Card number on the prescription mail-order form and submit it to the mail-order company, similar to any other Visa transaction. Payment will be taken directly from available funds in your Full-Purpose Health Care FSA and paid to the mail-order company for eligible expenses.
- You can use the Card to pay a bill for qualified Full-Purpose Health Care FSA expenses. Write the Card number on your statement and send it back to the health care provider. Payment will be taken directly from available funds in your Full-Purpose Health Care FSA and paid to the health care provider for eligible expenses.
- You will always be required to submit verification of expenses when using your Card to pay a bill. You may want to consider the Pay My Provider option instead. See the “Pay My Provider (PMP) payment option” section on page 5-20 for more information.
- If your health care provider does not accept Visa Cards as a form of payment, you can set up a Pay My Provider payment through your Full-Purpose Health Care FSA to have WageWorks issue the payment on your behalf. This method is similar to a bill payment feature you might use with your personal checking account. See the “Pay My Provider (PMP) payment option” section on page 5-20 for more information.
If you use your Card to pay for ineligible expenses or expenses for which you do not have the required documentation, you will be required to pay back the improper payment amounts to WageWorks for credit to the Full-Purpose Health Care FSA. See the “Ineligible payments or reimbursements” section on page 5-20 for more information.

Using the Card with the Limited Dental/Vision FSA
If you are enrolled in the Limited Dental/Vision FSA, your Card can only be used to pay for qualified out-of-pocket dental and vision provider expenses. For all other dental and vision expenses (for example, reading glasses purchased from a general merchandise store), you will need to pay out of pocket and submit a claim, with required documentation, for reimbursement. You may use your Card at a dental or vision provider that accepts Visa Cards for out-of-pocket dental and vision costs, such as:

- Copayments, coinsurance, and deductibles for eligible dental and vision expenses
- Dental and orthodontic expenses
- Vision expenses and LASIK surgery

Note: You may not use your Card to pay for any medical, prescription drug, or other health care expenses. Over-the-counter drugs are not eligible for reimbursement under the Limited Dental/Vision FSA, even if you have a prescription.

If you are enrolled in the Limited Dental/Vision FSA and you use the Card at a dental or vision provider, and WageWorks is unable to verify your patient out-of-pocket responsibility, WageWorks will require that you submit an itemized receipt or an Explanation of Benefits from your dental or vision plan to verify your patient out-of-pocket responsibility.

If WageWorks is unable to determine that a Card transaction was used for eligible dental or vision expenses according to IRS regulations, WageWorks will ask you to submit a Card Use Verification Form. If WageWorks does not receive the form with all required documentation within 90 days of the transaction, your Card will be suspended and the amount will be deducted from your next requested Pay Me Back reimbursement check. For more information on resolving Card suspensions, see the “Card suspensions” section on page 5-13.

It is your responsibility to manage your balance and allow ample time for all transactions (including Card transactions, Card Use Verification Forms, and claims and expense documentation) to clear. Also keep in mind that reimbursement requests can be used to offset outstanding Card use verifications, so make sure all Card Use Verification Forms are submitted in a timely manner. Please see the “Required expense documentation” section on page 5-19 for more information.

Access your account at https://www.wageworks.com regularly to see if you have any Card transactions that need verification. Make sure you page through all Alerts & Messages that pop up when you first access the WageWorks website as they are designed to notify you of Card transactions that require verification. Simply follow the prompts online to respond to the Card use verification request to restore your account to its good standing. Due to the time sensitivity of the Card verification requests, it is strongly recommended that you provide your email address to WageWorks by accessing your account and updating your profile. If you do not provide WageWorks with a valid email address, a single notification will be mailed to you. You will not receive notification in any other way.

Access WageWorks’ Support Center at https://www.wageworks.com to view the web tutorial to learn more about the Card Use Verification Form and process.

Unverified Card transactions can be resolved as follows:

1. Go to https://www.wageworks.com and download your latest Card Use Verification Form.
2. Print out the prefilled Card Use Verification Form.
3. Review the form for information about how and where to submit your receipts, payments, or both.
4. Complete and sign the form.
5. Submit the form along with a detailed receipt as indicated on the form. For more information, see the “Required expense documentation” section on page 5-19.

For your receipt (or any documentation) to be valid, it must include the following five specific pieces of information required by the IRS:

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

After WageWorks receives your Card Use Verification Form and required documentation, if you have a valid email address on file you will receive an automatic email notification when your form has been processed, and if you do not have a valid email on file you will receive an Explanation of Benefits by mail when your form has been processed. If denied, you will be advised of the denial reason, such as ineligible expense.
When using your Card during the grace period (January 1 to March 15), the Card will automatically use your previous year’s funds first if any funds remain. In addition, Card use must occur prior to the March 15 grace period deadline in order to apply to the prior year. Any Card use after the March 15 grace period deadline will apply to the current year and cannot be used to pay for expenses incurred in the prior year. Please keep in mind that if you have any unreimbursed claims to submit for the previous year, you must submit these claims before using your Card during the grace period. Otherwise, if you use your Card for claims incurred during the grace period, you may not have sufficient funds left in your previous year’s account to be reimbursed for claims incurred in the previous year. If you do not have any funds remaining from the previous year or were not enrolled in the previous year, the Card will automatically deduct funds from the available balance of your current year’s Limited Dental/Vision FSA.

**Important note:** If you are enrolled in a Limited Dental/Vision FSA, your Card is limited to dental and vision provider expenses. Therefore, any grace period medical expenses under a prior Full-Purpose Health Care FSA must be paid out of pocket and you'll need to submit a paper claim, with required documentation, for reimbursement. When using your Card, note the following:

- Your Card can only be used to pay exact amounts you owe for qualified dental and vision expenses. If your purchase includes nonqualified expenses, you must pay for those items separately with another form of payment and you will not be able to manually claim these expenses later.

- If your qualified Limited Dental/Vision FSA items are not purchased with your Card, you must submit a claim with a copy of your valid receipt (or other valid documentation such as an Explanation of Benefits) to be reimbursed. For more information, see the “**Claims and appeals**” section starting on page 5-19.

- You can use the Card to pay a bill for qualified dental and vision services. Write the Card number on your statement and send it back to the dental or vision care provider. Payment will be taken directly from available funds in your Limited Dental/Vision FSA and paid to the dental or vision care provider for eligible expenses.

- You will always be required to submit verification of expenses when using your Card to pay a bill. You may want to consider the Pay My Provider option instead. See the “**Pay My Provider (PMP) payment option**” section on page 5-20 for more information.

- If your dental or vision provider does not accept Visa Cards as a form of payment, you can set up a Pay My Provider payment through your Limited Dental/Vision FSA to have WageWorks issue the payment on your behalf. This method is similar to a bill payment feature you might use with your personal checking account. See the “**Pay My Provider (PMP) payment option**” section on page 5-20 for more information.

- If you use your Card to pay for ineligible expenses or expenses for which you do not have the required documentation, you will be required to pay back the improper payment amounts to WageWorks for credit to the Limited Dental/Vision FSA. See the “**Ineligible payments or reimbursements**” section on page 5-20 for more information.

**The importance of keeping receipts**

Because the Full-Purpose Health Care FSA and Limited Dental/Vision FSA are IRS-regulated benefits, you should save all of your related itemized receipts. WageWorks may contact you to submit a receipt to verify an expense. When asked to verify an expense, you will need to submit the original detailed receipt to show that you paid for eligible products or services or both. For more information, see the “**Required expense documentation**” section on page 5-19.

If you are not able to provide the required receipt documentation for your original expense, you may substitute another expense and the related receipt for any eligible products or services that you have not previously claimed through your Full-Purpose Health Care FSA or Limited Dental/Vision FSA.

**Misplaced receipts**

If you can’t produce a receipt for an expense, your options may range from submitting a substitute receipt to paying back the FSA for the amount of the transaction. Access your WageWorks account to review your options. If there are Card transactions that require your attention, you will be notified when you access your account online. Simply follow the prompts to submit your Card receipt. Your prompt attention is required to resolve any amount that requires substantiation. The claims administrator, WageWorks, is required to ensure that 100% of FSA funds are used only for eligible products and services and that any ineligible payments are not reimbursed.

If such receipts aren’t sent in the time frame indicated in the correspondence, your Card may be suspended until the issue is resolved. For information on resolving Card suspensions, see the “**Card suspensions**” section on page 5-13.
Eligible (or qualified) expenses

To be eligible for reimbursement from your FSA, the expense must be as follows:

- **For the Full-Purpose Health Care FSA**, the expense must be for medical, dental, or vision care as defined in Internal Revenue Code Section 213. For more information about deductible expenses, consult your tax advisor.

- **For the Limited Dental/Vision FSA**, the expense must be for dental or vision as defined in Internal Revenue Code Section 213. Consult your tax advisor if you have additional questions.

- Premiums or contributions for medical coverage are not eligible for reimbursement from either the Full-Purpose Health Care FSA or the Limited Dental/Vision FSA.

- Under the Patient Protection and Affordable Care Act, over-the-counter drugs are only eligible for reimbursement under the Full-Purpose Health Care FSA if accompanied by a prescription. This means items such as cough medicines, pain relievers, acid controllers, and diaper rash ointment require a prescription that must be submitted along with the reimbursement request. Insulin will continue to be eligible for reimbursement without a prescription.

Note: For over-the-counter drugs requiring a prescription, participants in the Full-Purpose Health Care FSA will be required to pay out of pocket and submit a Pay Me Back claim with your receipt and prescription for reimbursement.

- WageWorks provides a list of possible eligible expenses — including over-the-counter items that may or may not require a physician's prescription under the Full-Purpose Health Care FSA — that can be accessed on the WageWorks website. If you don’t have internet access, you can call WageWorks for a list of eligible expenses.

- Incurred while you are participating in the FSA.

- For your or your eligible dependents’ benefit.

- Incurred during the plan year or within the grace period of January 1 to March 15 of the following plan year. For more details about the grace period, see the “Some rules to know” section on page 5-6.

- Not reimbursed by another source.

Note: An expense is incurred when the service is received, not when payment is made. However, the IRS allows for advance payment for orthodontia expenses if it is required to receive the services.

Ineligible expenses

The FSAs do not allow reimbursements for certain specific expenses, including but not limited to the items listed below.

Note: The ineligible expenses listed below apply to either the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, as applicable. Medical and prescription drug expenses are never allowed under the Limited Dental/Vision FSA.

- Charges for the following, even if recommended by your doctor:
  - Charges for any illegal treatment
  - Charges for over-the-counter drugs that do not have a prescription, except insulin
  - Cosmetic treatment or surgery, unless it improves a deformity due to a birth defect, disease, or trauma
  - Drugs or over-the-counter products that are considered cosmetic or used solely for cosmetic purposes (for example, over-the-counter products or prescriptions used to treat hair loss, thinning hair, unwanted hair growth, hair removal, or all of these factors, or for teeth whitening procedures, products, or both)
  - Exercise, athletic, or health club membership (except as noted under Eligible Expenses on [https://www.wageworks.com](https://www.wageworks.com))
  - Household help
  - Massages
  - Nursing care for a healthy baby
  - Weight loss programs (except as specifically described under Eligible Expenses on [https://www.wageworks.com](https://www.wageworks.com))

- Claims filed after the claims filing deadline.

- Concierge fees and expenses for health care services, unless itemization is provided for each date of service.

- Expenses incurred after the Health Care FSA Plan ends or your participation in the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA option ends.

- Expenses incurred before your effective date of participation in the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA.

- Expenses not allowed as a deduction or credit for federal income tax purposes.

- Expenses paid for with HRA or HSA dollars.

- Expenses you also claim as a deduction or credit for federal or state income tax purposes.
• Premiums paid for any medical, dental, or vision plan coverage or long-term care insurance.

• In addition to all of the above ineligible expenses, the Limited Dental/Vision FSA does not allow reimbursement for medical and prescription drug expenses.

Claims and appeals

WageWorks is the claims administrator and processes requests for reimbursement from the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA. WageWorks is the named fiduciary for claims and appeals under ERISA and has the sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the Health Care FSA Plan and respective options. Procedures for filing claims under the Full-Purpose Health Care FSA and Limited Dental/Vision FSA are set forth below.

Additional claims and appeals information for the Health Care FSA Plan is included in “Appendix A: Claims and Appeals.”

Filing a claim

To be reimbursed for an eligible expense from the applicable Full-Purpose Health Care FSA and Limited Dental/Vision FSA, file a completed and signed Pay Me Back claim form with the claims administrator, WageWorks. (If you are using your Card to pay for eligible expenses under a Full-Purpose Health Care FSA or Limited Dental/Vision FSA, you do not need to file an additional claim form. You do need, however, to save your itemized receipts in case verification is required by WageWorks.)

The claim form is available to you online. You can access the WageWorks website at https://www.wageworks.com.

You may file your claim by one of the three methods noted below:

• Fax the completed and signed claim form along with all required supporting expense documentation to WageWorks at 1-877-353-9236 (keep a copy of the faxed documentation and the fax confirmation)

• Scan the completed and signed claim form, along with all required supporting expense documentation, and upload through https://www.wageworks.com

• Mail the completed and signed claim form, along with all required supporting expense documentation, to:

  Claims Administrator — WageWorks
  PO Box 14053
  Lexington, KY 40512

See the “Required expense documentation” section starting on this page for more information.

Claims filing time frame

Claims for expenses incurred during a plan year (or applicable grace period) must be postmarked, faxed, or electronically filed as noted above by April 30 of the following year. You can file a claim as soon as you have incurred an eligible expense or accumulate your expenses and file them together. You may submit claims under the applicable FSA only for expenses incurred while you were a Full-Purpose Health Care FSA or Limited Dental/Vision FSA participant.

If, following the April 30 deadline, you have a remaining balance in your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA after all eligible expenses for the prior plan year have been reimbursed, your remaining balance will be forfeited and you will lose the opportunity to request additional reimbursements from this balance. For example, if you have not filed for reimbursement of your eligible expenses for your 2017 Full-Purpose Health Care FSA or Limited Dental/Vision FSA option by April 30, 2018, 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. You cannot receive a refund for the unused balance.

Required expense documentation

Required documentation may include the following, as determined by WageWorks:

• For medical, dental, or vision copayment or coinsurance expenses related to health care services, an Explanation of Benefits (EOB) from your medical, dental, or vision plan after your claim has been processed, indicating the patient name, date of service, type of service, service provider, amount charged, amount paid by the applicable plan, and the amount you owe.

• For medical, dental, or vision expenses, a copayment receipt, indicating the patient name, date of service, provider, and copayment amount paid. The receipt must state that it is a copayment receipt.

• If you do not have medical, dental, or vision coverage under a health plan, you must provide evidence of your expense that includes an itemized billing statement from the provider indicating the patient name, date of service, type of service, service provider, and amount charged for the service. Balance due statements, general statements of account, credit card receipts, cash register receipts, or canceled checks are not acceptable forms of documentation.
• Certain over-the-counter drugs, medicines, and biologicals are eligible for reimbursement under the Full-Purpose Health Care FSA but require a physician’s prescription, letter of medical necessity, or directive. For eligible over-the-counter health care items, in addition to the prescription, letter of medical necessity, or directive, you must submit a detailed cash register receipt that shows the description of the item (for example, allergy medicine), where the item was purchased, the charge for the item, and the date the item was purchased.

Keep copies of all documentation submitted. If you fax your documentation, keep a copy of the faxed documentation and the fax confirmation until you have confirmed that WageWorks has processed your claim or verified any Card transactions and you have received your reimbursement.

**Pay My Provider (PMP) payment option**

Pay My Provider (PMP) gives you the ability to have WageWorks make a payment directly from your account to your provider for eligible expenses for Full-Purpose Health Care FSA or Limited Dental/Vision FSA transactions. You can request a one-time or recurring payment.

You can set up a PMP payment (similar to online bill pay with your personal checking account) to come directly out of the current account balance in your applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA. An itemized invoice or other appropriate proof of service is required before PMP payments can be issued. The invoice or other documentation must include the dates of service, type of service, service provider, patient’s name, and cost of service. The payment request will remain in the system until the documentation is submitted, but recurring requests that continue through the subsequent plan year, under the same plan, will not have payments to providers issued until the new plan year begins on January 1. One-time requests will be processed and distributed just a few days after the submitted invoice or documentation has been approved (payment requests may not be entered before the service start date). Recurring payments will be mailed on the requested payment date. You are permitted to enter a requested payment date that is up to 10 calendar days before the due date shown on the contract, if required. A one-time payment cannot be canceled once it is submitted. A recurring payment, however, may be canceled up to 10 days before the requested payment date.

To request a PMP payment, sign on to https://www.wageworks.com, and follow the necessary prompts to submit (mail, fax, or scan and upload) your itemized invoice or other appropriate documentation to complete your Pay My Provider request.

**Claim payment**

Your eligible claims will be paid up to your current account balance. For the applicable Full-Purpose Health Care FSA or Limited Dental/Vision FSA option, the total annual contribution amount you elect for the plan year is available for you to use as of the first day of the plan year. As a result, your “current account balance” at any point during the plan year is that amount less any claims paid. You will be reimbursed for claims the same way you receive your pay. If you receive your pay by direct deposit, your reimbursement will be deposited to the same account. If you receive your pay by check, you’ll receive your reimbursement by check. If you want to change the method or account by which you receive your pay and FSA reimbursements, submit a Direct Deposit Authorization form to Wells Fargo Payroll or change your direct deposit account online through Teamworks.

You may sign up for direct deposit at any time on Teamworks or you may get a Direct Deposit Authorization form (HRS44590) from Forms Online on Teamworks.

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 WageWorks website, your Explanation of Benefits will be sent via email; otherwise, you will receive a hard copy in the mail. The minimum claim payment is $25. Claims will not be paid until they total at least $25 (except for the final claim payment for the plan year). This minimum reimbursement amount does not apply to Card transactions for eligible expenses.

**Ineligible payments or reimbursements**

If you use your Card to pay for ineligible expenses or you receive reimbursements from the FSA that later are found to be ineligible or for which you do not have the required documentation, you will be required to pay back the improper payment amounts to WageWorks for credit to the FSA. WageWorks will contact you for more information about the expense in question and with options for resolving the issue.

Your options for repayment are either:

• Send a check by April 30 of the year following the year in which the expense was incurred to repay your account for this amount if you no longer have the detailed receipt or if you accidentally used your Card to pay for an ineligible expense. This repayment will make the amount available for eligible products and services as planned.

• Do nothing, and the amount under Receipt or Repayment Needed will be deducted from your next payment for claims. This is the automatic repayment option that is available if your balance will cover the amount. If not, send a check as described above, or you may be subject to collection procedures.
If you fail to make this repayment, Wells Fargo may withhold the amount of the improper payment from your wages or other compensation to the extent consistent with applicable law. Wells Fargo or WageWorks may also withhold making reimbursement on future valid claims until the amount due to be repaid is recovered. Your Card will be suspended, you will not be able to use your Card until all repayments due are made, and you may be subject to corrective action, including termination of your employment. For information on resolving Card suspensions, see the “Card suspensions” section on page 5-13.

Account activity and status
Access your account online to review and print your real-time account information at any time of the day or month. Your account activity and status include information about:

- Your current and available funds
- Ineligible payments or your recent payments, claims, and reimbursements
- Special messages about your account

Make sure to review your account activity and status thoroughly.

If you have entered your preferred email address on the WageWorks website, WageWorks will provide you with critical activity-based email alerts, such as the claims payment and Card use verification notices. You will be able to check your balance 24 hours a day, 7 days a week by accessing your account at https://www.wageworks.com or by calling WageWorks at 1-877-924-3967.

If you do not provide your email address to WageWorks, you will receive a Card verification request by mail. You will only receive one if you have any Card transactions that need to be verified as eligible expenses.

The different statuses for each of your Card transactions are:

- Pending. WageWorks is in the process of collecting information about this Card transaction from various sources and possibly the merchant. If WageWorks is able to obtain information to verify this Card transaction paid for eligible products and services, you will not be required to submit a receipt, other documentation, or a repayment. If not, you will be asked to do so in this section of next month’s statement. In any case, be sure to save your receipts with your important tax documents for the year.

- No (Further) Action Required. WageWorks was able to resolve this amount without further action required from you, based on information available to WageWorks from a receipt, other documentation, or a repayment you submitted.

- Receipt or Repayment Needed. WageWorks was not able to verify that this amount of the Card transaction was used to pay for eligible products and services. You are now required to submit a receipt or other documentation that describes exactly what you paid for or repay the FSA for the expense. Pay Me Back claims received before verification of a transaction will be applied to the outstanding amount and not reimbursed. Refer to the Card Use Verification Form for more information about your options to resolve this amount.

- See Card Use Verification Form (instructions). A Card Use Verification Form contains a list of options to resolve an unverified Card payment from your account. If you have a Card transaction that requires verification, a link to the Card Use Verification Form will be prominently displayed when you access your account at https://www.wageworks.com. The Card Use Verification Form includes a list of options to resolve an unverified payment from your account. Use this form to submit the actual receipt or a substitute receipt to show that this amount was used for eligible products and services or to submit a check to repay your account for this amount.

Full-Purpose Health Care FSA and Limited Dental/Vision FSA questions, denied reimbursement, and appeals
If you have a question or concern about a Full-Purpose Health Care FSA claim or a Limited Dental/Vision FSA claim processed by WageWorks, you may call WageWorks (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 WageWorks under the terms of the Health Care FSA Plan. If you call WageWorks, 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 WageWorks within 180 days of the date your claim is denied regardless of any verbal discussions that have occurred regarding your claim. More detailed information on Full-Purpose Health Care FSA and Limited Dental/Vision FSA appeals is provided in “Appendix A: Claims and Appeals.”
# Chapter 6
## Day Care Flexible Spending Account

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<td>Day Care FSA claim questions, denied reimbursement, and requests for review</td>
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</tr>
</tbody>
</table>
## Contacts

<table>
<thead>
<tr>
<th>Information about the Day Care Flexible Spending Account</th>
<th>WageWorks, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-877-WageWorks (1-877-924-3967)</td>
</tr>
<tr>
<td></td>
<td>Teamworks</td>
</tr>
<tr>
<td>To email claims</td>
<td><a href="mailto:paymeback@wageworksclaims.com">paymeback@wageworksclaims.com</a></td>
</tr>
<tr>
<td>To fax claim forms toll-free</td>
<td>1-877-353-9236</td>
</tr>
<tr>
<td>To file claims online, view account information and activity, or find forms</td>
<td><a href="https://www.wageworks.com">https://www.wageworks.com</a></td>
</tr>
<tr>
<td></td>
<td>Access from Teamworks.</td>
</tr>
<tr>
<td>Information about enrollment</td>
<td>Team Member Care (formerly known as the HR Service Center)</td>
</tr>
<tr>
<td></td>
<td>1-877-HRWELLS (1-877-479-3557), option 2</td>
</tr>
<tr>
<td></td>
<td>Team Member Care accepts relay service calls.</td>
</tr>
<tr>
<td></td>
<td>TDD/TTY users may call 1-800-988-0161.</td>
</tr>
</tbody>
</table>
This chapter — along with “Chapter 1: An Introduction to Your Benefits” and the “Plan information,” “Participating employers,” and “Future of the plans” sections of “Appendix B: Important Notifications and Disclosures” — contains information applicable to the Wells Fargo & Company Day Care Flexible Spending Account (the Day Care FSA). The Day Care FSA is not subject to or governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The basics

Introduction

The Day Care FSA is sponsored by Wells Fargo & Company, and is administered by WageWorks. The Day Care FSA allows you to set aside money on a before-tax basis to pay for eligible day care expenses associated with caring for your children under the age of 13, or elderly or disabled dependents whom you claim as tax dependents. It is important for you to understand that the Day Care FSA cannot be used for health care expenses (including medical, dental, and vision expenses). Your decision to participate in this voluntary account should be based on your needs and personal situation. It is also important that you understand the limitations of a Day Care FSA before you decide whether to participate (see the “Day Care FSA rules” section starting on page 6-4). Be sure to read this chapter carefully before enrolling in a Day Care FSA.

You may contribute from $130 to $5,000 annually to the Day Care FSA, subject to limitations imposed by applicable law and IRS guidance. For example, highly compensated team members, as defined by applicable IRS guidance, may only contribute up to $2,500. For more information, see the “Contribution limits” section on page 6-7.

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, is actively looking for work, is a full-time student, or is mentally or physically incapable of self-care.

The information provided in this chapter is not intended to provide tax advice for any individual’s specific situation. If you have any questions regarding the tax implications surrounding your specific situation, including questions about whether the dependent care tax credit or Day Care FSA is more favorable to you, please consult your tax advisor.

Note: The Day Care FSA is subject to the Employee Retirement Income Security Act of 1974 (ERISA), which is a federal law that establishes minimum standards for the operation of pension, health, and other welfare benefit plans. ERISA’s fiduciary duty rules, including the exclusive benefit rule, govern how a company may legally use participant forfeitures. The exclusive benefit rule provides that plan assets, including participant forfeitures, cannot be used for the benefit of the employer and must be used for the exclusive purpose of providing benefits to plan participants and beneficiaries, or dependents, and defraying reasonable plan administration expenses. Consistent with the requirements under ERISA, participant forfeitures are used to pay for administrative expenses of the Day Care FSA as well as to provide benefits to plan participants and their dependents. 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 6-12.

Claims administrator

WageWorks, Inc. (WageWorks) is the claims administrator and processes requests for reimbursement from the Day Care FSA, which is not subject to ERISA. WageWorks 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 part-time team member as described in the “Eligible team members” section in “Chapter 1: An Introduction to Your Benefits.”

Day Care FSA rules

Your contributions to, and reimbursements from, the Day Care FSA are designed to qualify for favorable tax treatment by the IRS. In exchange for these potential tax advantages, the IRS imposes strict rules about how you may use your Day Care FSA. Before enrolling, consider the rules described below and the rest of the information in this chapter. Please note the information provided in this chapter is not intended to provide tax advice for any individual’s specific situation. If you have any questions regarding the tax implications surrounding your specific situation, please consult with your own tax advisor.

Note: For the purposes of the Day Care FSA, the “plan year” is the same as a calendar year, beginning on January 1 and ending the following December 31.

- The Day Care FSA, also known as a dependent care account, can be used to pay for eligible day care expenses for children under the age of 13, or elderly or disabled dependents whom you claim as tax dependents.
- Money set aside for the Day Care FSA cannot be used to pay for health care expenses (including medical, dental, and vision expenses).
- You cannot transfer your Day Care FSA balance to any other flexible spending account, including a Full-Purpose FSA or Limited Dental/Vision FSA under the Wells Fargo & Company Health Care Flexible Spending Account Plan.
- You may not use the Day Care FSA and request tax credits for the same expenses. When you file your tax returns, you cannot deduct or claim a tax credit for expenses paid by the Day Care FSA.
- You must use the money in your Day Care FSA for eligible day care expenses that are incurred (1) in the same year you contribute the money or during the grace period described below, and (2) while you are a participant in the Day Care FSA. You cannot be reimbursed for day care expenses incurred before your participation begins or after your participation ends.
- If you are enrolled in the Day Care FSA on December 31 of a plan year and have not exhausted your balance, you qualify for a grace period — January 1 through March 15 of the year following the plan year. 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, 2016, you incur $100 worth of eligible day care expenses on January 15, 2017, and you submit a request for reimbursement on January 30, 2017. At that time, you have a $50 balance still remaining in your 2016 Day Care FSA. Accordingly, $50 of your $100 eligible day care expenses will be reimbursed to you from your 2016 account and the remaining $50 may be eligible to be reimbursed from your 2017 account if you have elected the Day Care FSA for 2017.

- You must submit completed claims to WageWorks by April 30 of the year following the plan year. The claim must include proper expense documentation for eligible day care expenses incurred during the plan year or during the applicable grace period. To ensure that your claims are complete by this date, submit your initial claims early in case you are asked for additional information or are missing any items. Claims or expense documentation submitted after the April 30 deadline will not be reimbursed. A completed claim consists of a signed Pay Me Back claim form and required documentation, as determined by WageWorks.

- If the April 30 claims submission deadline has passed and you have a remaining balance from the previous plan year, the previous plan year’s balance is forfeited and you no longer have the opportunity to request additional reimbursements from that previous year’s balance. You cannot receive a refund for the unused balance.

- A Day Care FSA expense is incurred when the day care service is received, not when you pay the provider. For example, if you pay for day care services in advance, you cannot receive reimbursement for those expenses until after the services have been provided.

- After you enroll in the Day Care FSA, you may not increase or decrease your elected contributions unless you have a day care-related Qualified Event. For more information, see the “Changing coverage” and the “Qualified Events” sections in “Chapter 1: An Introduction to Your Benefits.”
• No deduction will be made from your pay if your available pay is less than your Day Care FSA per-pay-period contributions. If this happens, missed contributions will be made up by increasing your per-pay-period contribution amount for the rest of the plan year beginning with the next payroll period in which available pay allows for this deduction.

• 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 call Team Member Care (formerly known as the HR Service Center) on September 10 and provide complete information about the day care-related Qualified Event, allowing you to 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 $1538.46 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, plus the minimum per-pay-period contribution of $5.00 for the remainder of the plan year. 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 call Team Member Care (formerly known as the HR Service Center) on September 10 and provide complete information about the day care-related Qualified Event, allowing you to 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 benefits-eligible status 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 benefits-eligible status, both periods are separate and distinct periods. Note: Your election amount after your rehire or return to benefits-eligible status 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 6-7.

For example:

– Your original annual contribution for the Day Care FSA is $2,000, elected during Annual Benefits Enrollment.
– Assuming 26 pay periods per plan year results in a $76.92 contribution per pay period.
– Your employment with Wells Fargo is terminated on March 15.
– You may only be reimbursed up to $461.54 (assuming six pay periods and a $76.92 per-pay-period contribution) for expenses incurred before March 15 since this is all that you contributed for the plan year.
– You are rehired on August 15 with coverage effective October 1 (the first of the month after one full calendar month of service). You are eligible to elect $4,538.46 ($5,000 annual limit minus $461.54 taken in previous payroll deductions), unless you are a highly compensated team member, in which case you are eligible to elect $2,038.46 ($2,500 annual limit minus $461.54 taken in previous payroll deductions). However, you elected a $1,200 Day Care FSA annual contribution amount (assuming six pay periods remain in the plan year results in a $200 contribution per pay period).
– You may only be reimbursed up to $1,200 for expenses incurred between October 1 and the end of the plan year, including the grace period.
– You are not permitted to enroll for COBRA continuation coverage to extend your participation in the Day Care FSA.

Your contributions

Your contribution amount

If you enroll in a Day Care FSA, your before-tax pay will be reduced each pay period by the per-pay-period contribution amount and will be rounded to the nearest penny. 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 6-4 if you experience a midyear day care-related Qualified Event that impacts your annual contribution.

You can authorize contributions in any amount with a:

• Minimum of $130 per plan year or $5.00 per pay period.
• Maximum of $5,000 per plan year, subject to limitations imposed by applicable IRS guidance. Certain team members may be subject to a lower contribution limit. See the “Contribution limits” section on page 6-7.

The Day Care FSA is a bookkeeping account established to keep track of your contributions and reimbursements. Except as otherwise required by law, amounts credited to the Day Care FSA remain the property of Wells Fargo & Company until reimbursed to participants. When you participate in the Day Care FSA, your account is credited as you make per-pay-period contributions. This means that your current balance equals your actual contributions made to date, less any reimbursements. You may only receive reimbursement up to the amount of your current balance.
**Contribution limits**

In general, participants may contribute up to $5,000 on a before-tax basis to a Day Care FSA. However, the IRS has established other limitations on your before-tax Day Care FSA reimbursements in addition to the $5,000 annual contribution maximum, as described in the table below. Certain team members who are highly compensated employees, under applicable IRS guidance, may be subject to a lower annual contribution limit in the Day Care FSA. Total annual contributions generally cannot exceed the amount of your pay for the plan year.

<table>
<thead>
<tr>
<th>If you are:</th>
<th>The following IRS limit on before-tax reimbursements will apply:</th>
</tr>
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<tbody>
<tr>
<td>Single</td>
<td>The lesser of:</td>
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<tr>
<td></td>
<td>• $5,000</td>
</tr>
<tr>
<td></td>
<td>• Your earned income</td>
</tr>
<tr>
<td>Married and file a joint tax return</td>
<td>The lesser of:</td>
</tr>
<tr>
<td></td>
<td>• $5,000</td>
</tr>
<tr>
<td></td>
<td>• Your earned income</td>
</tr>
<tr>
<td></td>
<td>• Your spouse’s earned income (if you’re married at the end of the tax year)</td>
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<tr>
<td>Married and file separate tax returns</td>
<td>The lesser of:</td>
</tr>
<tr>
<td></td>
<td>• $2,500</td>
</tr>
<tr>
<td></td>
<td>• Your earned income</td>
</tr>
<tr>
<td></td>
<td>• Your spouse’s earned income (if you’re married at the end of the tax year)</td>
</tr>
<tr>
<td>Married with spouse who is either:</td>
<td>• For one dependent: $250 for each month your spouse is disabled or a full-time student, up to $5,000 per year</td>
</tr>
<tr>
<td>• Physically or mentally incapable of</td>
<td></td>
</tr>
<tr>
<td>self-care</td>
<td>• For two or more dependents: $500 for each month your spouse is disabled or a full-time student, up to $5,000 per year</td>
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<tr>
<td>• A full-time student at least five</td>
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<tr>
<td>months a year</td>
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If your spouse also participates in a dependent care assistance program where he or she works, the total amount reimbursed on a before-tax basis in both your Day Care FSA and your spouse’s dependent care assistance program cannot exceed $5,000 per year, subject to the other limitations imposed by applicable IRS guidance. You and your spouse cannot claim the same expenses. Please consult your tax advisor for further information.
How to enroll

New hire and employment classification change enrollment
If you are eligible, you may enroll in the Day Care FSA by going to the benefits enrollment site on Teamworks, at work or at home, or by calling Team Member Care (formerly known as the HR Service Center) during your designated enrollment period. For more information, see the “How to enroll” section in “Chapter 1: An Introduction to Your Benefits.”

If you enroll during your designated enrollment period, your participation begins on the first of the month following one full calendar month of service in a benefits-eligible position. If you enroll, you must participate for the remainder of the plan year (calendar year) unless you have a Qualified Event that permits dropping coverage. For more information, see the “Changing coverage” section in “Chapter 1: An Introduction to Your Benefits.”

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: An Introduction to Your Benefits.”

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 benefits-eligible status
If you are an eligible rehired team member, or you return to a benefits-eligible status, and you want to participate in the Day Care FSA, you must reenroll during your designated enrollment period as described under the “New hire and employment classification change enrollment” section on this page. In addition, your election amount after your rehire or return to benefits-eligible status 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 “Day Care FSA rules” section starting on page 6-4 for more information relating to your Day Care FSA after a rehire or return to a benefits-eligible status.

Changing participation during the plan year

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: An Introduction to Your Benefits,” and the “Leave of absence” section on this page.

Employment classification change
If you begin participating in the Day Care FSA and then change your employment classification to a non-benefits-eligible position, you are no longer eligible to participate in the Day Care FSA. Your Day Care FSA contributions stop after the change in employment status is processed. You may, however, still submit claims for eligible expenses incurred up to the date your employment classification changed to a non-benefits-eligible 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, call Team Member Care (formerly known as the HR Service Center) 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 call to Team Member Care, whichever is later.
When you return from a leave of absence in the same plan year in which your leave began:

- If you return to work from leave at a benefits-eligible status 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 at a benefits-eligible status 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 be made up by increasing your per-pay-period contribution amount for the rest of the plan year. That way, you will make the total annual contribution amount that you elected when you enrolled.

- If you revoked your Day Care FSA election when you began your approved leave of absence and you return to work in a benefits-eligible 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 calling Team Member Care (formerly known as the HR Service Center) 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 your call to Team Member Care to request reenrollment.

When you return from a leave of absence in a subsequent plan year:

- If you revoked your Day Care FSA election while you were on an approved leave of absence and you return to work in a benefits-eligible 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 calling Team Member Care (formerly known as the HR Service Center) 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 your call to Team Member Care to request reenrollment.

Claims
If you participate in the Day Care FSA, generally, you cannot claim expenses incurred during your leave. To be eligible for reimbursement under the Day Care FSA, the day care expenses must be incurred so you can work or look for work.

Annual Benefits Enrollment while on leave
You may make an Annual Benefits Enrollment election for the Day Care FSA while you are on an approved leave of absence. However, if you are on a leave of absence on January 1, without recognized sources of income replacement, contributions, including any applicable missed contributions for the current plan year, will begin when you return to work in a benefits-eligible position. Your payroll deduction will be adjusted for the rest of the plan year to account for any applicable missed contributions while you were on leave.
When participation ends

Participation in the Day Care FSA ends if Wells Fargo stops providing the Day Care FSA or on the date that:

• Your Wells Fargo employment is terminated or you retire.
• You no longer meet the eligibility requirements.
• You cancel participation, as permitted by Day Care FSA provisions.
• You die.

* For more information on the Day Care FSA’s amendment and termination procedures, see the “Future of the plans” section in “Appendix B: Important Notifications and Disclosures.”

You may continue to file claims for eligible expenses incurred before the date your participation ends until your available account balance is zero or until April 30 of the next calendar year, whichever occurs first. As noted previously, eligible expenses are incurred when the day care service is received and not when you pay the provider.

Example: If you start participating in the Day Care FSA at the beginning of the plan year and then terminate participation 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 dependents or the executor of your estate 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. 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

<table>
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<th>Option</th>
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<tr>
<td>Pay My Provider</td>
<td>You want to schedule automatic payments to your day care provider for eligible expenses from available funds in the Day Care FSA</td>
<td>“Pay My Provider (PMP) payment option” section on page 6-13</td>
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<tr>
<td>Pay Me Back</td>
<td>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</td>
<td>“Filing a claim” section starting on page 6-11</td>
</tr>
</tbody>
</table>
Chapter 6: Day Care Flexible Spending Account

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 your personal 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 your tax advisor.

Eligible Day Care FSA expenses
The Day Care FSA covers only eligible day care expenses, not health care expenses. To be eligible, you must incur these day care-related expenses for the care of an eligible dependent (see above) so you (and your spouse if you are married) can work or look for work. Payments for the following are generally eligible expenses:

- Care providers inside or outside your home
- Day care provided at a licensed nursery school, day care center, or day camp (including summer day camp) in compliance with applicable state and local laws
- Before- or after-school programs
- Any other expenses that would be considered eligible for a dependent care credit for federal income tax purposes

Note: An expense is incurred when the service is received, not when a payment for that service is made.

Ineligible Day Care FSA expenses
The Day Care FSA does not pay certain expenses, including:

- Child support payments
- Claims filed after the claims filing deadline
- Education expenses (for example, tuition for kindergarten, primary school, or secondary school)
- Expenses incurred after the Day Care FSA ends or your participation in the Day Care FSA ends
- Expenses incurred before your effective date of participation in the Day Care FSA
- Health care expenses (including medical, dental, and vision expenses)
- Payments to your spouse, your child under age 19 (whether a dependent or not), or other dependent for taking care of your children
- Personal expenses for dependents, such as the cost of clothing and meals
- Overnight camp
- Any expenses you claim for the dependent care tax credit on your federal income tax return
- Other expenses not permitted to be reimbursed by applicable law or IRS guidance

However, you can submit claims for nursery school care that includes some meals or educational activities as part of the regular fees, or household services that include caretaking services for one or more eligible dependents.

Claims and requests for review
WageWorks is the claims administrator and processes requests for reimbursement from the Day Care FSA. WageWorks 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, WageWorks. The claim form is available to you on the WageWorks website at https://www.wageworks.com. You may file your claim by one of the three methods noted below:

- Fax the completed and signed claim form, along with all required supporting expense documentation, to WageWorks at 1-877-353-9236 (keep a copy of the faxed documentation and the fax confirmation).
- Scan the completed and signed claim form, along with all required supporting expense documentation, and upload through https://www.wageworks.com.
• Mail the completed and signed form, along with all required supporting expense documentation, to:
  Claims Administrator — WageWorks
  PO Box 14053
  Lexington, KY 40512

See the “Required expense documentation” section on this page for more information.

Claims filing time frame
Claims for expenses incurred during a plan year, and applicable grace period, must be postmarked, faxed, or electronically filed as noted 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 2017 Day Care FSA by April 30, 2018, any remaining 2017 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 WageWorks:

• If your provider does not sign the claim form, you must submit a receipt that includes the provider’s name, the dates of service, a description of service provided, the child’s name, and the amount charged. 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 indicate the provider’s name, the dates of service, a description of service provided, the child’s name, and the 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 contributed to date at any point during the plan year, less any claims paid. (Claims that cannot be paid in full because of insufficient funds will not be reimbursed until further contributions sufficient to reimburse the total amount of such claims are received.)

You will be reimbursed for claims the same way you receive your Wells Fargo pay. If you receive your pay by direct deposit, your reimbursement will be deposited to the same account. If you receive your pay by check, you’ll receive your reimbursement by check. If you want to change the method or account by which you receive your pay and Day Care FSA reimbursements, submit a Direct Deposit Authorization form to Wells Fargo Payroll or change your direct deposit account on Teamworks.

You may sign up for direct deposit at any time on Teamworks, or get a Direct Deposit Authorization form (HRS44590) from Forms Online, also available on Teamworks.

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 WageWorks website, your Explanation of Benefits will be sent via email. Otherwise, you will receive a hard copy in the mail. The minimum claim payment is $25. Claims will not be paid until they total at least $25 (except for the final claim payment for the plan year).

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 WageWorks website, WageWorks will provide you with critical, activity-based email alerts, such as your claims payment information. You will be able to check your balance 24 hours a day, 7 days a week by accessing your account at https://www.wageworks.com, or by calling WageWorks at 1-877-924-3967.

Pay My Provider (PMP) payment option
Pay My Provider (PMP) gives you the ability to have WageWorks make a payment directly from the Day Care FSA to your provider for eligible expenses for Day Care FSA transactions. You can request a one-time or recurring payment. You can set up a PMP payment (similar to online bill pay with your personal checking account) to come directly out of your Day Care FSA. An itemized invoice or other appropriate proof of service is required before PMP payments can be issued. The invoice or other documentation must include the dates of service, type of service, service provider, dependent’s name, and cost of service. The payment request will remain open in the system until the documentation is submitted. One-time requests will be processed and distributed just a few days after the submitted invoice or documentation has been approved. You are permitted to enter a requested payment date that is up to 10 calendar days before the due date shown on the contract, if required. A one-time payment cannot be canceled once it is submitted. A recurring payment, however, may be canceled up to 10 days before the requested payment date.

To request a PMP payment, sign on to https://www.wageworks.com, and follow the necessary prompts to submit (mail, fax or scan and upload) your itemized invoice or other appropriate documentation to complete your Pay My Provider request.

Day Care FSA claim questions, denied reimbursement, and requests for review
If you have a question or concern about a claim processed by the claims administrator, WageWorks, you may call WageWorks (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 WageWorks within 180 days of the date the claim was processed. If your request is not submitted within this time period, it will not be reviewed. Submit a letter explaining the reason you believe the day care expense should be reimbursable under the terms of the Day Care FSA and any documentation that supports your request. Although the request for review is not governed by the appeal provisions, the request for review should be submitted to:

WageWorks Claims Appeal Board
PO Box 991
Mequon, WI 53092-0991

WageWorks will review your request and issue the final determination to you.
# Chapter 7
## Life Insurance Plan

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### Contacts

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<td>Information about premiums for life insurance</td>
<td>Check your enrollment materials, or go to Teamworks.</td>
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<td>Forms</td>
<td>Go to Forms Online on Teamworks or contact Metropolitan Life Insurance Company (“MetLife”), as noted in this chapter.</td>
</tr>
<tr>
<td>Information about current coverage, enrollment, or to file a claim</td>
<td>Team Member Care (formerly known as the HR Service Center) 1-877-HRWELLS (1-877-479-3557), option 2  Team Member Care accepts relay service calls. TDD/TTY users may call 1-800-988-0161.</td>
</tr>
<tr>
<td>Claims and Statement of Health status</td>
<td>Metropolitan Life Insurance Company (“MetLife”) 1-800-638-6420</td>
</tr>
<tr>
<td>Information about Minnesota continuation enrollment and filing a claim while on continuation coverage (Minnesota residents only)</td>
<td>Metropolitan Life Insurance Company (“MetLife”) 1-888-252-3607</td>
</tr>
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</table>
The information in this chapter — along with that in “Chapter 1: An Introduction to Your Benefits,” “Appendix B: Important Notifications and Disclosures,” and “Appendix D: Leaves of Absence and Your Benefits” — constitutes the Summary Plan Description ( SPD) for the life insurance coverage available to regular and part-time team members under the Wells Fargo & Company Life Insurance Plan (the Life Insurance Plan).

The basics

General information

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

- Basic Term Life
- Optional Term Life
- Spouse/Partner Optional Term Life
- Dependent Term Life

Wells Fargo pays the premium for Basic Term Life coverage, so all benefits-eligible team members are automatically enrolled. To participate in one or more of the other term life insurance coverage options listed in the “Your life insurance coverage options at a glance” table starting on page 7-4, you’ll need to actively enroll in each coverage option separately and pay the applicable premium. See the “Your life insurance coverage options at a glance” table starting on page 7-4 for important information about your term life insurance coverage options.

All four types of term life insurance coverage offered under the Life Insurance Plan are covered by one group term life insurance policy.

The SPD and Group Policy Number 164933-1-G issued by Metropolitan Life Insurance Company (“MetLife”), along with any certificates, policy amendments, riders, and endorsements, constitute the official plan document for the Life Insurance Plan. If there are differences between the SPD and the Life Insurance Plan policy, the Life Insurance Plan policy governs your rights to benefits.

If you would like a copy of the Active Wells Fargo Group Term Life Certificate of Insurance for the Life Insurance Plan, contact Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2. Individual Certificates of Insurance are not available.

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

Insurer and claims administrator

The Life Insurance Plan is insured by Metropolitan Life Insurance Company (“MetLife”). MetLife has the discretionary authority to administer claims and interpret benefits under the Life Insurance Plan and respective coverage options.
Your life insurance coverage options at a glance

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<td><strong>Optional Term Life</strong></td>
<td><strong>Spouse/Partner Optional Term Life</strong></td>
</tr>
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<td>Coverage levels¹</td>
<td>1 × covered pay²</td>
<td>You select coverage level in increments of $25,000</td>
</tr>
<tr>
<td></td>
<td>Minimum: $10,000</td>
<td>Minimum: $25,000</td>
</tr>
<tr>
<td></td>
<td>Maximum: $50,000</td>
<td>Maximum: $3,000,000</td>
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<tr>
<td>Who pays the premium</td>
<td>Wells Fargo — you are automatically enrolled.</td>
<td>You — if you enroll.</td>
</tr>
<tr>
<td>Cost</td>
<td>None — Wells Fargo pays the full cost.</td>
<td>You pay a premium based on level of coverage elected, age, and tobacco- and/or nicotine-user status.</td>
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<td>Insurer</td>
<td>MetLife</td>
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<td>Policy number</td>
<td>Group Policy: No. 164933-1-G</td>
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<td>Coverage type</td>
<td>Group term life insurance</td>
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<td>Who's eligible</td>
<td>Regular and part-time team members, as defined in “Chapter 1: An Introduction to Your Benefits.”</td>
<td>Your spouse or domestic partner, as defined in “Chapter 1: An Introduction to Your Benefits.”</td>
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<tr>
<td>Who's not eligible</td>
<td>Flexible team members, as defined in “Chapter 1: An Introduction to Your Benefits.”</td>
<td>Your spouse or domestic partner who does not meet eligibility criteria defined in “Chapter 1: An Introduction to Your Benefits.”</td>
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<tr>
<td>Beneficiary</td>
<td>Person, persons, trust, or institution that you designate.³</td>
<td>You are automatically the designated beneficiary of your spouse or domestic partner.</td>
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1. For more information on coverage levels, including applicable Statement of Health requirements, see the “How to enroll” section on page 7-7.
2. See the “Plan benefits” section on page 7-11 for more information on how covered pay is determined.
3. See the “Beneficiaries” section on page 7-10 for more information on how benefits are paid if you fail to designate a beneficiary.
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<tr>
<td><strong>Basic Term Life</strong></td>
<td>First of the month after one full calendar month of service from your date of hire or employment classification change, provided that you are actively at work on the day coverage is scheduled to begin. (See the “Delayed effective date” section on page 7-8.)</td>
<td>First of the month after one full calendar month of service from your date of hire or employment classification change, provided that you enrolled your spouse or domestic partner, or dependent child during your designated enrollment period and you are actively at work on the day coverage is scheduled to begin. (See the “Delayed effective date” section on page 7-8.)</td>
</tr>
<tr>
<td><strong>Optional Term Life</strong></td>
<td>First of the month after one full calendar month of service from your date of hire or employment classification change, provided that you enrolled during your designated enrollment period and you are actively at work on the day coverage is scheduled to begin. (See the “Delayed effective date” section on page 7-8.)</td>
<td>First of the month after one full calendar month of service from your date of hire or employment classification change, provided that you enrolled your spouse or domestic partner, or dependent child during your designated enrollment period and the spouse or domestic partner, or dependent child is not confined on the day coverage is scheduled to begin (see the “Delayed effective date” section on page 7-8).</td>
</tr>
<tr>
<td><strong>Coverage effective date</strong></td>
<td><strong>Late enrollment</strong></td>
<td><strong>Decrease or cancel coverage anytime</strong></td>
</tr>
<tr>
<td>There is no late enrollment since you automatically receive coverage.</td>
<td>To apply online for late enrollment in Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage: 1. Go to mybenefits.metlife.com/wellsfargo. 2. Register on the MetLife site by entering your name, employee ID number, ZIP code, and email address. After you register, you’ll be asked to create your own username and password. You can also find the Statement of Health form on Forms Online on Teamworks. Simply fill out the form online, print it out, sign the form, and then send the completed form to MetLife at the address shown on the form. Coverage is subject to approval by MetLife.</td>
<td>You cannot decrease or cancel coverage since you automatically receive coverage. For Optional Term Life or Spouse/Partner Optional Term Life, call Team Member Care (formerly known as the HR Service Center) to decrease or cancel coverage. Change is effective the first of the month after your call to Team Member Care (formerly known as the HR Service Center). Coverage cannot be decreased or canceled retroactively. Call Team Member Care (formerly known as the HR Service Center) to cancel coverage. Cancellation is effective the first of the month after your call to Team Member Care. Coverage cannot be canceled retroactively. (No decreased coverage is available since there is only one coverage level.)</td>
</tr>
<tr>
<td>Life insurance on you</td>
<td>Life insurance on your spouse or domestic partner</td>
<td>Life insurance on your dependent children</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td><strong>Increase coverage</strong></td>
<td>You may not increase coverage.</td>
<td>Not applicable since there is only one coverage level.</td>
</tr>
<tr>
<td></td>
<td>To apply online for increased coverage under Optional Term Life or Spouse/Partner Optional Term Life:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Go to mybenefits.metlife.com/wellsfargo.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Register on the MetLife site by entering your name, employee ID number, ZIP code, and email address.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>After you register, you’ll be asked to create your own username and password.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>You can also find the Statement of Health form on Forms Online on Teamworks. Simply fill out the form online, print it out, sign the form, and then send the completed form to MetLife at the address shown on the form.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coverage is subject to approval by MetLife.</td>
<td></td>
</tr>
<tr>
<td><strong>Qualified Events</strong></td>
<td>Not applicable since coverage is automatically provided.</td>
<td>You can enroll in or increase Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage without submitting a Statement of Health form within 60 days of the following Qualified Events:</td>
</tr>
<tr>
<td></td>
<td>• 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 father of a child.)</td>
<td>• 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 father of a child.)</td>
</tr>
<tr>
<td></td>
<td>• Marriage or creation of a domestic partnership. However, if you have a domestic partnership, whether or not your domestic partner is enrolled in any of your Wells Fargo benefits, and then subsequently marry your domestic partner, you cannot enroll in or increase coverage without providing a Statement of Health form because your previously existing domestic partner who becomes your spouse is not a newly eligible dependent.</td>
<td>• Marriage or creation of a domestic partnership. However, if you have a domestic partnership, whether or not your domestic partner is enrolled in any of your Wells Fargo benefits, and then subsequently marry your domestic partner, you cannot enroll in or increase coverage without providing a Statement of Health form because your previously existing domestic partner who becomes your spouse is not a newly eligible dependent.</td>
</tr>
<tr>
<td></td>
<td>• Death of a spouse or domestic partner, legal separation, divorce, or dissolution of a domestic partnership. (These Qualified Events only apply for Optional Term Life coverage.)</td>
<td>• Death of a spouse or domestic partner, legal separation, divorce, or dissolution of a domestic partnership. (These Qualified Events only apply for Optional Term Life coverage.)</td>
</tr>
<tr>
<td></td>
<td>Enroll at 1 × covered pay or increase by 1 × covered pay.</td>
<td>Enroll at $25,000 or increase by $25,000.</td>
</tr>
<tr>
<td></td>
<td>Enroll.</td>
<td>Enroll.</td>
</tr>
</tbody>
</table>

**Suicide exclusion**: None

**Porting or conversion once your Wells Fargo coverage ends**: Port to a group policy or convert to individual policy for Basic Term Life or Optional Term Life coverage.

**Coverage when you’re not working (approved leave of absence)**: Basic Term Life coverage will generally continue for a maximum of 24 months.

Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage will continue as long as you pay the premium. (See “Appendix D: Leaves of Absence and Your Benefits.”)
Who's eligible

Regular and part-time Wells Fargo team members and their eligible dependents as described in “Chapter 1: An Introduction to Your Benefits” are eligible for coverage under the Life Insurance Plan. Flexible team members and their dependents are not eligible for coverage. Please see the “Your life insurance coverage options at a glance” table starting on page 7-4 for more information about eligibility for each life insurance coverage option.

How to enroll

Initial enrollment

Eligible regular and part-time team members are automatically enrolled in Basic Term Life coverage, which is one times covered pay with a minimum of $10,000 and a maximum of $50,000, the first of the month following one full calendar month of service in a benefits-eligible position, subject to the requirement that they be actively at work on their first day of coverage as described below.

You may enroll in Optional Term Life coverage, Spouse/Partner Optional Term Life coverage, Dependent Term Life coverage, or any combination thereof during your designated enrollment period. If you enroll during the designated enrollment period, coverage becomes effective the first of the month following one full calendar month of service in a benefits-eligible position, subject to the applicable actively at work requirement and the spouse/partner and dependent nonconfinement requirement.

Optional Term Life coverage is subject to the requirement that you be actively at work on the first day of coverage as described in the “Delayed effective date” section on page 7-8.

- Spouse/Partner Optional Term Life coverage and Dependent Term Life coverage are not subject to the requirement that you be actively at work on the first day of coverage, but they are subject to the nonconfinement clause (see the “Delayed effective date” section on page 7-8).

To enroll, access the Benefits Enrollment site on Teamworks, at work or at home, during your designated enrollment period. If you do not enroll during the designated enrollment period, you must follow the procedures described in the “Late enrollment” section starting on page 7-9.

Optional Term Life

You can enroll from one to ten times your covered pay with a minimum of $10,000 and a maximum of $3,000,000. Enrollment for one to four times your covered pay during your initial enrollment period does not require completion of the Statement of Health form. Enrollment for five to ten times your covered pay requires you to provide a completed Statement of Health form for the amount above four times your covered pay and is subject to MetLife’s underwriting guidelines, whether you enroll during initial enrollment or under late enrollment provisions. Approved amounts over four times your covered pay will be effective the first of the month following the date MetLife approves your application, subject to the actively at work requirement (see the “Delayed effective date” section on page 7-8), and the associated increase in premium deductions will be reflected in your paycheck that includes the pay period covering the effective date.

Spouse/Partner Optional Term Life

You can enroll in coverage for your spouse or domestic partner in $25,000 increments up to $250,000. Enrollment at the $25,000 level does not require completion of the Statement of Health form. Enrollment for coverage at the $50,000 to $250,000 levels requires your spouse or domestic partner to provide a completed Statement of Health form. Approval for levels above $25,000 is subject to MetLife’s underwriting guidelines and will be effective the first of the month following the date MetLife approves the application, subject to the nonconfinement clause (see the “Delayed effective date” section on page 7-8), and the associated increase in premium deductions will be reflected in your paycheck that includes the pay period covering the effective date.

Dependent Term Life

If you enroll in Dependent Term Life coverage during your initial designated enrollment period or following one of the Qualified Events as described in the row titled “Qualified Events” on page 7-6, completion of the Statement of Health form is not required.

Enrollment in Dependent Term Life coverage automatically covers all of your eligible dependent children as well as any future newly eligible dependent children, as long as you continue enrollment in the Dependent Term Life coverage. You do not need to separately enroll each individual dependent child. 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 is eligible; otherwise, you will be paying for a benefit that you will not be able to use. Each enrolled eligible dependent child will have $20,000 in coverage. For more information about Dependent Term Life enrollment, see the “Changing coverage” section on page 7-8.
Employment classification changes
If your employment classification changes and you become newly eligible for benefits, you must follow the initial enrollment process, described above, to enroll in coverage.

Delayed effective date
If you are not actively at work on the day coverage would start, your Basic Term Life and Optional Term Life 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.

For Spouse/Partner Optional Term Life and Dependent Term Life, coverage will start even if you are not actively at work, provided that the person to be covered is not hospitalized or confined 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”). The nonconfinement clause does not apply to a newborn child.

Changing coverage

Qualified Events
You may make the following changes without providing a Statement of Health form if you contact Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days of your Qualified Event as described in the row titled “Qualified Events” on page 7-6:

- Enroll in or increase your Optional Term Life coverage by one times your covered pay.
- Enroll in Spouse/Partner Optional Term Life coverage at a coverage level of $25,000 (or for birth, adoption, or placement for adoption, increase existing Spouse/Partner Optional Term Life coverage by $25,000).
- Enroll in Dependent Term Life coverage at a coverage level of $20,000 per child.

Note: If you have a domestic partnership and then subsequently marry your domestic partner, you cannot enroll in or increase coverage without providing a completed Statement of Health form because your previously existing domestic partner who becomes your spouse is not a newly eligible dependent.

For Optional Term Life coverage, the effective date of the change will be the first of the month following the date of the event or the first of the month following the date you call Team Member Care (formerly known as the HR Service Center), whichever is later, provided that you are actively at work (see the “Delayed effective date” section on this page for more information). You cannot request to increase your team member Optional Term Life coverage if you are not actively at work. However, you may request a change by calling Team Member Care within 60 days of the date you return to being actively at work. After you are actively at work and call Team Member Care, your change in coverage will be effective the first of the month following your call.

For Spouse/Partner Optional Term Life coverage and Dependent Term Life coverage, the effective date of the change will be the first of the month following the date of the event or the date you call Team Member Care (formerly known as the HR Service Center), whichever is later, even if you are not actively at work, subject to the nonconfinement clause (see the “Delayed effective date” section on this page). Your newly eligible spouse/domestic partner will automatically be covered at the $25,000 level for 60 days from the date he or she becomes eligible. Coverage will terminate after 60 days if you do not enroll in Spouse/Partner Optional Term Life coverage.

Your first newly eligible dependent child will automatically be covered for the first 60 days from the date he or she becomes eligible. Coverage will terminate after 60 days if you do not enroll in Dependent Term Life coverage. This only applies to your first eligible dependent child; subsequent dependent children will not be automatically enrolled if you haven’t already enrolled in Dependent Term Life coverage.

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 nonconfinement clause (see the “Delayed effective date” section on this page). If your dependent becomes ineligible for coverage, see the “Decreasing or canceling coverage” section on page 7-9.
Late enrollment
If you do not enroll in Optional Term Life coverage, Spouse/Partner Optional Term Life coverage, or Dependent Term Life coverage during your initial designated enrollment period or because of a Qualified Event, you may enroll at any time. However, late enrollment procedures require you to submit a Statement of Health form, regardless of the level of coverage selected.

MetLife will determine whether to approve the late enrollment application based on its underwriting guidelines. If approved, coverage will become effective on the first day of the month following the date MetLife approves the application. 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 7-8). For Spouse/Partner Optional Term Life coverage and Dependent Term Life coverage, the effective date of coverage will not be delayed if you’re not actively at work, but the date of coverage will be subject to the nonconfinement clause (see the “Delayed effective date” section on page 7-8).

For Dependent Term Life coverage, it is possible that some, but not all, of your eligible children will be approved for coverage. If this is the case, those children who are approved will be covered, and those not approved will not be covered. You can reapply for a declined child at any time, but another completed Statement of Health form will be required.

To access the Statement of Health form, go online to mybenefits.metlife.com/wellsfargo or to Forms Online on Teamworks, or contact Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2.

Decreasing or canceling coverage
You may decrease or cancel your Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage at any time by calling Team Member Care (formerly known as the HR Service Center) and speaking with a customer service representative. You must call Team Member Care at 1-877-HRWELLS (1-877-479-3557), option 2, to notify the plan administrator in the event an enrolled dependent child is no longer eligible for the Dependent Term Life coverage. The coverage will be changed effective the first of the month following your call to Team Member Care. Coverage cannot be decreased or canceled retroactively.

Increasing coverage
You may apply to increase your Optional Term Life or Spouse/Partner Optional Term Life coverage at any time. However, a completed Statement of Health form is required unless you are increasing coverage as permitted due to a Qualified Event. For more information, see the “Qualified Events” section on page 7-8. MetLife will determine if the application is approved for the increased coverage. If the application is approved, the increased coverage will be effective the first of the month following the approval, subject to the actively at work requirement for Optional Term Life coverage and the nonconfinement clause for Spouse/Partner Optional Term Life coverage (see the “Delayed effective date” section on page 7-8 for more information).

Any increase in coverage due to an increase in covered pay or an increase in coverage level will be subject to the actively at work provision (see the “Delayed effective date” section on page 7-8 for more information).

Cost
Wells Fargo pays the entire cost for Basic Term Life coverage. You do not pay for any part of the coverage.

You pay premiums for Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage through after-tax payroll deductions each pay period. Wells Fargo does not contribute to the premium.

The premium rate for Optional Term Life is calculated based on your coverage amount, which is calculated based on the level of coverage chosen and your age and tobacco- and/or nicotine-user status, as applicable. If your covered pay changes or if you move to a new age group, your premium rates may change. Please refer to the “Covered pay” section starting on page 7-11 for a definition of covered pay.

The premium rate for Spouse/Partner Optional Term Life is calculated based on the level of coverage chosen and your spouse/partner’s age and tobacco- and/or nicotine-user status, as applicable.

Premium rates for coverage for individuals who have not used any tobacco and/or nicotine products during the last 12 months are lower than the premium rates for tobacco and/or nicotine users. Tobacco and nicotine products include but are not limited to cigarettes, electronic cigarettes, cigars, pipes, chewing tobacco, nicotine gum, and nicotine patches.
If your or your spouse’s or domestic partner’s tobacco-and/or nicotine-user status changes after you enroll, you may change your or your spouse’s or domestic partner’s tobacco-and/or nicotine-user status at any time; however, changing status from tobacco and/or nicotine user to nonuser status requires that the insured be tobacco- and nicotine-free for at least 12 months. To change your own tobacco- and/or nicotine-user status, go to Teamworks or call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2. You will need to call Team Member Care to change your spouse’s or domestic partner’s tobacco-and/or nicotine-user status. The change will be effective the first of the month following the date you input the change on Teamworks or call Team Member Care. Tobacco- and/or nicotine-user status cannot be changed retroactively.

For example, if you enroll as a tobacco and/or nicotine nonuser but later begin to use tobacco or nicotine products, you must change your status to tobacco and/or nicotine user. Conversely, if you enroll as a tobacco and/or nicotine user and go 12 months without using any tobacco and/or nicotine products, you may change to tobacco- and/or nicotine-nonuser status. In either case, the new premium will be effective the first of the month following the date you input the change on Teamworks or call Team Member Care. Tobacco- and/or nicotine-user status cannot be changed retroactively.

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 on the online Beneficiary Designation Tool. If a minor child is named as the beneficiary, the proceeds will go into a locked interest-bearing account until the child turns 18. If a guardian 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. If you need to change your beneficiaries during the year, you may do so at any time by going to the online Beneficiary Designation Tool on Teamworks. The change will be effective on the date you update your beneficiary designation.

For Spouse/Partner Optional Term Life and Dependent Term Life coverage, benefits are automatically paid to you or, if you’re deceased, to your estate.

For Basic Term Life and Optional Term Life coverage, if a beneficiary is not designated, the beneficiary dies before you and no contingent beneficiary is named, or the contingent beneficiary has also died before you, the death benefit may be paid to your survivors in the following order:

1. Your surviving spouse or domestic partner
2. Equally among your surviving biological and adopted children*
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

* 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 the child as your beneficiary.

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 beneficiaries

Primary and contingent 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 beneficiary receives the whole death benefit amount only if the primary beneficiary dies before you.

Changing beneficiaries

You may change the beneficiaries under Basic Term Life and Optional Term Life coverage at any time by going to the online Beneficiary Designation Tool on Teamworks. The change will be effective on the date you update your beneficiary designation.

Payout if no surviving or designated beneficiaries

For Spouse/Partner Optional Term Life and Dependent Term Life coverage, benefits are automatically paid to you or, if you’re deceased, to your estate.

For Basic Term Life and Optional Term Life coverage, if a beneficiary is not designated, the beneficiary dies before you and no contingent beneficiary is named, or the contingent beneficiary has also died before you, the death benefit may be paid to your survivors in the following order:

1. Your surviving spouse or domestic partner
2. Equally among your surviving biological and adopted children*
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

* 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 the child as your beneficiary.
Transfer of ownership
You may transfer your ownership, also referred to as assigning your rights, under the Life Insurance Plan to another individual or a Trust. If you transfer your ownership, you are transferring your ownership for all coverage options in which you are enrolled, including Basic Term Life, Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage. This 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. Also, keep in mind that transfers of ownership of life insurance are valid only if they are not collateral assignments or assignments for consideration (that is, viatical assignments, which are prohibited). 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 Team Member Care (formerly known as the HR Service Center) 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, you are responsible for notifying the new owner of any changes to the Life Insurance Plan, your coverage, and employment status that result in the cancellation of benefits.

Plan benefits
The death benefit under Basic Term Life coverage is one times your covered pay with a plan minimum of $10,000 and a maximum of $50,000. For Optional Term Life coverage, the death benefit is based on the salary multiple (one to ten) you have enrolled in times your covered pay with a plan minimum of $10,000 and a maximum of $3,000,000. Your death benefit will be calculated using the covered pay in effect at the time of your death except if you die while on a Salary Continuation Leave, in which case the death benefit will be calculated using the covered pay in effect on the day immediately before the first day of your Salary Continuation Leave. 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 is determined by the job classification code (job class code) for your position on the Wells Fargo HR Information System (HRIS).

Job class code 2
Most positions within Wells Fargo are job class code 2. For job class code 2 positions, covered pay is defined as your annual base salary. Annual base salary is your hourly rate of pay multiplied by the number of standard hours indicated on HRIS. Base salary may be expressed as an annual, monthly, or hourly amount on HRIS, but the rate is annualized for the purpose of determining your benefit under Basic Term Life and Optional Term Life coverage. Base salary includes amounts designated as before-tax contributions you make to Wells Fargo-sponsored benefit plans. 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 commute subsidies).
Job class codes 1 and 5
Mortgage Consultant Participant pay category positions are generally job class 1.

Variable Incentive Compensation (VIC) pay category positions are generally job class code 5. VIC applies to jobs with a pay structure designed to deliver 40% or more of target cash through incentives that are paid primarily on a monthly or quarterly basis. Assignment of jobs to VIC (job class code 5 on HRIS) requires approval of Wells Fargo Enterprise Compensation.

For both job class codes 1 and 5, covered pay is defined as your benefits base. Benefits base is calculated and recalculated quarterly, and earnings are annualized based on base salary and incentives, incentive bonuses, and commissions paid in the last 12 months, or on a combination of these factors. (In a leave of absence situation, your benefits base is frozen on the day before the day your leave begins.) These earnings are then divided by the number of months with earnings greater than 0, with a minimum benefits base of $20,000. Benefits base includes amounts designated as before-tax contributions you make to other Wells Fargo benefit plans. Benefits base does not include some forms of compensation such as overtime pay, shift differentials, hiring and retention bonuses, noncash awards, and perquisites (such as parking or auto allowance or commute subsidies).

Covered pay under the Life Insurance Plan may be calculated differently for certain job class code 1 and 5 positions as explained below.

If you: (1) are a designated VIC Financial Consultant, Financial Advisor, or Financial Advisor Manager with Wealth Brokerage Services or the Private Client Group, (2) are in your first 12 months of employment, and (3) have an annualized benefits base that has never exceeded the following first-year minimum covered pay amounts:

- **For Financial Consultants:** Your first-year minimum covered pay base amount is $50,000 for both Basic Term Life and Optional Term Life coverage.
- **For Financial Advisors and Financial Advisor Managers:** Your first-year minimum covered pay amount is $50,000 for Basic Term Life coverage and $125,000 for Optional Term Life coverage.

The first-year minimum covered pay will remain in place until the earlier of: (1) 12 months from your job start date or (2) until your quarterly benefits base calculation exceeds your first-year minimum covered pay amount. Once your benefits base exceeds your first-year minimum covered pay amount, then going forward, covered pay will be determined under the standard benefits base practice, as stated in the paragraph above, even if your benefits base later falls below the first-year minimum covered pay amount.

It’s your responsibility to verify the impact of any changes to your life insurance coverage. You can view the impact by accessing your Benefits Confirmation Statement after the first payroll period of each quarter; see “Changing coverage” section on page 7-8.

**Seat belt benefit for Basic Term Life**

The death benefit will be increased by an additional 20% of the basic life insurance amount, not to exceed $10,000, but no less than $1,000, if a loss of life occurs due to a covered accident while properly using a seat belt in a passenger vehicle. Note that the driver must have been a licensed driver and not intoxicated, impaired, or under the influence of alcohol or drugs at the time of the accident, and the official accident report must indicate that a seat belt was properly used. If the official accident report is unclear about the proper use of a seat belt, the seat belt benefit is limited to $1,000. No seat belt benefit is payable if the official accident report is either not provided or if the report indicates that no seat belt was worn.
Accelerated Benefit

Basic Term Life, Optional Term Life, and Spouse/Partner Optional Term Life coverage provides an Accelerated Benefit, which is an advance payment before death of a part or the total amount of the plan benefit. Contact Wells Fargo Survivor Services directly at 1-877-374-7987 to initiate a claim for an Accelerated Benefit. To qualify for an Accelerated Benefit, the insured must:

- Be insured for at least $10,000.
- Have not assigned his or her rights under the Life Insurance Plan.
- Be terminally ill (expected to die within 12 months).
- Send proof of terminal illness to MetLife that the insured’s life expectancy, because of sickness or injury, is 12 months or less. This must include certification by a physician. MetLife retains the right to have the insured medically examined at MetLife’s expense to verify the medical condition.

An Accelerated Benefit is not available if the insured is:

- Required by law to use this as an option to meet the claims of creditors, whether in bankruptcy or otherwise
- Required by a government agency to use this as an option to apply for, obtain, or keep a government benefit or entitlement

The Accelerated Benefit option will end on the earliest of:

- The date life insurance coverage terminates;
- The date you transfer ownership of (assign) your life insurance benefits; or
- 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.

<table>
<thead>
<tr>
<th>Benefit amount</th>
<th>Full Accelerated Benefit</th>
<th>Partial Accelerated Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of the life insurance coverage amount in effect at the time of the request, up to a maximum of:</td>
<td>Any partial amount of the life insurance coverage amount in effect at the time of the request, up to a maximum of:</td>
<td></td>
</tr>
<tr>
<td>$50,000 for Basic Term Life</td>
<td>$50,000 for Basic Term Life</td>
<td></td>
</tr>
<tr>
<td>$1,000,000 for Optional Term Life</td>
<td>$1,000,000 for Optional Term Life</td>
<td></td>
</tr>
<tr>
<td>$250,000 for Spouse/Partner Optional Term Life</td>
<td>$250,000 for Spouse/Partner Optional Term Life</td>
<td></td>
</tr>
<tr>
<td>Policy in force</td>
<td>Coverage ceases.</td>
<td>Coverage remains in force less the amount accelerated.</td>
</tr>
</tbody>
</table>

Benefits received under this Accelerated Benefit provision may be taxable. The insured should seek assistance from a personal 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.
Claims and appeals

Filing a claim

The beneficiary must follow these steps to file a claim for benefits under the applicable coverage option of the Life Insurance Plan:

1. The beneficiary should contact Team Member Care (formerly known as the HR Service Center) 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. (Team Member Care will inform Survivor Operations, who will send the beneficiary an initial communication regarding benefit actions required.)

2. The beneficiary should be prepared to send a certified death certificate to Survivor Operations after receiving the initial communication mentioned above (Survivor Operations will notify MetLife of the death after step 1 has been completed and a certified death certificate has been received).

After the documentation above is received, MetLife will determine if a death benefit is payable. 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.

Life Insurance Plan initial claim determination, denials, and appeals

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

When any claim is denied in whole or in part, you or your beneficiary has the right to submit a request for review to MetLife. Requests for review must be in writing and submitted within 60 days of receiving MetLife’s decision. Submissions for a request for review need to be sent to:

MetLife
Group Life Claims
PO Box 6100
Scranton, PA 18505-6100

If you or your beneficiaries request a review, include the following:

- The reason you or your beneficiaries believe the claim was improperly denied; and
- Any written comments, documents, records, or other information deemed appropriate.
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; and
• 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 questions relating to participation of eligible team members and eligibility
• Determination of all relevant facts
• Determination of the documents, records, and other information that are relevant to a claim for benefits
• Determination of the amount and type 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 “Claims and appeals” section on page 7-14 for more information).

**Benefits when you’re not working**

When you’re on an approved leave of absence, you may be able to continue life insurance coverage even if you are not actively working for Wells Fargo. For Basic Term Life, coverage may continue during your approved leave, generally up to a maximum of 24 months.

For Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage, you must continue paying the premiums during your leave to keep the coverage. If coverage was canceled due to nonpayment of premiums or you elected to cancel the coverage, you can apply for coverage at any time but will be required to submit a completed Statement of Health form for review by MetLife. For additional information on continuing your benefit while on an approved leave of absence, see “Appendix D: Leaves of Absence and Your Benefits.”
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:

<table>
<thead>
<tr>
<th>Event</th>
<th>Basic Term Life</th>
<th>Optional Term Life</th>
<th>Spouse/Partner Optional Term Life</th>
<th>Dependent Term Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your last day of employment takes place.</td>
<td>Coverage ends on the last day of the month for all life insurance coverage options.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You no longer meet the eligibility requirements.</td>
<td>Coverage ends on the last day of the month for all life insurance coverage options.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your spouse or dependent no longer meets the eligibility requirements.</td>
<td>NA</td>
<td>NA</td>
<td>Coverage ends on the last day of the month.</td>
<td>Coverage ends on the last day of the month.</td>
</tr>
<tr>
<td>You do not pay the required premium.</td>
<td>NA</td>
<td>Coverage ends on the last day of the month for which full payment was received.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The plan is terminated.</td>
<td>Coverage ends on the date the plan termination is effective.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You voluntarily cancel coverage.</td>
<td>NA</td>
<td>Coverage ends on the last day of the month in which you contact Team Member Care to request cancellation of your 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.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After coverage ends: Your options

Continuation for Minnesota residents

If you are a Minnesota resident and you leave Wells Fargo or you reduce your hours and are no longer eligible for benefits, you may be eligible to continue your life insurance coverage (Basic Term Life, Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life) under the Minnesota Continuation Law. You may elect to continue any one or more of the life insurance options in which you were enrolled. You may elect an amount up to or equal to the amount of coverage in effect on the date your applicable coverage ends.

You will receive a packet from MetLife explaining the enrollment process and a portability election form. To apply for continuation of life insurance coverage(s), complete the portability election form and return it to MetLife. Refer to the “How to apply — portability” section starting on page 7-17 for details. For questions on completing your form or if you do not receive a packet within 21 days of your coverage end date, contact MetLife at 1-888-252-3607.

Once you receive your packet from MetLife, contact MetLife with any questions regarding portability or conversion at the phone numbers listed on each of the forms included in the packet.

Portability (or porting)

Porting is one of the options available for continuing your Basic Term Life, Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage after your coverage through the Life Insurance Plan ends.

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/Domestic Partner Term Life: You can port all or a portion of your Spouse/Domestic Partner Term Life coverage up to a maximum of the lesser of your total Spouse/Domestic Partner Term Life coverage in effect on the date you elect to port or $250,000. Your Spouse/Domestic Partner 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. At age 25, each child may apply to continue their portable coverage by completing a portability election form.

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 1-888-252-3607.

If the portability information from MetLife is dated within 15 days after the date your coverage ends, you will have 31 days from the date your coverage ends to send the completed portability form and first premium payment to MetLife.

If the portability information from MetLife is dated more than 15 days but within 91 days from the date your coverage ends, you will have 45 days from the date of the portability information letter to send the completed portability form and first premium payment to MetLife.

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.

Retiree continuation
If you retire and continue your Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage under MetLife’s retiree continuation process, the premium you pay will be calculated based on the coverage amount continued and the insured’s age and tobacco- and/or nicotine-user status. Please note that you are only allowed to participate in retiree continuation once per lifetime. The premium will be established by MetLife, and you will no longer be covered under the Life Insurance Plan.

Unlike the portability described previously, retiree continuation is not offered for Basic Term Life insurance, but does allow you to continue all or a portion of your Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverage.

You must continue your Optional Term Life coverage as a retiree to continue any Spouse/Partner Optional Term Life or Dependent Term Life coverage.

The insured is not required to undergo a physical examination before continuing the coverage.

To be eligible for the retiree continuation option, you must meet at least one of the following criteria when you retire:

• You retire on or after age 55 with at least 10 years of service
• You have at least 80 points (based on age plus years of service)
• You retire at or after age 65 with one year of service

Exception: To be eligible for the retiree continuation option, a legacy Wachovia team member must have been a benefits-eligible team member on Wachovia’s payroll as of December 31, 2009, with at least 50 points (based on age plus years of service) as of January 1, 2010, and retire at age 50 or later with 10 years of service.

How to apply — retiree continuation
If you meet the retiree continuation eligibility requirements described above, you will receive information directly from MetLife regarding how to continue your coverage. If you want to continue your coverage, return the completed enrollment form to MetLife within 31 days from the date of the information letter. If you do not receive this information within 21 days of the date your coverage ends, contact MetLife at 1-866-492-6983.

The insured is not required to undergo a physical examination before continuing the coverage.
Conversion
You can convert your Basic Term Life, Optional Term Life, Spouse/Partner Optional Term Life, or Dependent Term Life coverage to individual life insurance policies if group coverage terminates for any reason other than failure to pay the required premium. Your spouse, domestic partner, or dependent may also convert his or her Spouse/Partner Optional Term Life or Dependent Term Life coverage in the event of your death or if he or she no longer meets the eligibility requirements.

How conversion works
• Conversions are to an individual life insurance policy, administered by Massachusetts Mutual Life Insurance Company (MassMutual). No disability or other benefits will be included.
• 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 financial professionals with MassMutual 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 MassMutual financial professional, or if you do not receive this informational letter within 21 days of the date your coverage ends, contact MetLife at 1-877-275-6387.

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.
# Chapter 8

## Business Travel Accident Plan

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</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
</tbody>
</table>
| Information about Business Travel Accident Plan provisions | Team Member Care (formerly known as the HR Service Center) 1-877-HRWELLS (1-877-479-3557), option 2  
  Team Member Care accepts relay service calls.  
  TDD/TTY users may call 1-800-988-0161. |
| Questions about Claims status                | Metropolitan Life Insurance Company (“MetLife”) 1-800-638-6420 |
The information in this chapter — along with that in “Chapter 1: An Introduction to Your Benefits” and “Appendix B: Important Notifications and Disclosures” — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Business Travel Accident Plan (the BTA Plan).

The basics

General information
The SPD is a summary of provisions of the Business Travel Accident Plan and its underlying fully insured policy issued by Metropolitan Life Insurance Company (“MetLife”). For further details, you can contact plan administration, and request a copy of the Blanket Accident Insurance Certificate. (See “Appendix B: Important Notifications and Disclosures” for the plan administrator’s address.) The SPD and Group Policy Number 164933-BTA issued by MetLife, along with any policy amendments, riders, and endorsements, constitute the official plan document for this BTA Plan. If there are differences between the SPD and the BTA Plan’s policy, the BTA Plan’s policy governs your rights to benefits.

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

Insurer and claims administrator
The BTA Plan is insured by Metropolitan Life Insurance Company (“MetLife”). MetLife is the named fiduciary and has sole and complete discretionary authority to administer claims and interpret benefits under the BTA Plan.

BTA coverage
BTA coverage helps provide financial protection if you are in a “covered accident” (as defined below) and within 365 days of the date of the covered accident any of the following happen. You:

• Die
• Become paralyzed
• Suffer the loss of limb, speech, hearing, or sight
• Are in a coma that commences within 365 days of the date of a covered accident
• Suffer brain damage

A “covered accident,” as used throughout this SPD, is defined as a sudden, unforeseeable, external event that results directly, and independently of all other causes, in a covered injury or covered loss and meets all of the following conditions:

• Occurs while you are insured under this BTA Plan.
• Occurs while you are on company-authorized Wells Fargo business travel; for a business trip lasting less 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.

1. When traveling on Wells Fargo business, coverage begins when you leave your home or place of work. Generally, coverage continues until you return home. You are protected in cases of accidents that occur while driving a vehicle (including a rental vehicle), riding as a passenger in someone else’s vehicle, or traveling in a nonexperimental commercial or company-owned aircraft, or other modes of transportation for business purposes. However, you are not covered for normal commuting between your home and place of work, nor are you covered if you are participating in any race or speed contest, or if you are driving any vehicle for pay or hire. In addition, you are not covered for any activity which is not reasonably related to or incidental to the purpose of travel for which coverage is provided by this BTA Plan. It will be deemed that your regular place of work has changed and traveling on business has ended if:
   a. You are expected to remain in the new location to which you have traveled on business for more than 180 days; or
   b. Wells Fargo deems a new location to be your regular place of work.

2. You are also covered under the “Felonious assault benefit” and the “Terrorist act business travel coverage” when you are on the premises of Wells Fargo during your regularly scheduled working hours at the time of the incident resulting in the covered accident, in addition to being covered while on authorized Wells Fargo business.

3. This benefit will not extend beyond the length of your business travel as approved by Wells Fargo, even if that approval is for more than 180 days.
### BTA Plan at a glance

<table>
<thead>
<tr>
<th>You cannot cancel coverage</th>
<th>Business Travel Accident (BTA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How do I enroll?</strong></td>
<td>You are automatically enrolled, if you are eligible</td>
</tr>
<tr>
<td><strong>MetLife policy number</strong></td>
<td>164933-BTA</td>
</tr>
<tr>
<td><strong>Type of ERISA plan</strong></td>
<td>Welfare benefit plan</td>
</tr>
<tr>
<td><strong>Who’s eligible</strong></td>
<td>Regular and part-time team members</td>
</tr>
<tr>
<td><strong>Who’s not eligible</strong></td>
<td>Flexible team members</td>
</tr>
<tr>
<td><strong>Beneficiary</strong></td>
<td>The person, persons, trust, or institution you designated (or if none, according to the “Payout if no surviving or designated beneficiary” section on page 8-5)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>None — Wells Fargo pays the full cost</td>
</tr>
<tr>
<td><strong>Coverage effective date</strong></td>
<td>Date of hire or employment classification change, provided that you are actively at work on the day coverage is scheduled to begin</td>
</tr>
<tr>
<td><strong>Cancel coverage</strong></td>
<td>You cannot cancel coverage</td>
</tr>
<tr>
<td><strong>Conversion</strong></td>
<td>No conversion privilege</td>
</tr>
<tr>
<td><strong>Coverage when you’re not working</strong> (approved leave of absence)</td>
<td>Coverage will not continue when you are not actively at work</td>
</tr>
</tbody>
</table>
| **BTA Plan death benefits**| 5 \(\times\) covered pay  
Maximum: 2,000,000, subject to the policy’s aggregate maximum accident limitation |

### Who’s eligible

Regular and part-time Wells Fargo team members, as described in “Chapter 1: An Introduction to Your Benefits” in this Benefits Book, are eligible to participate in the BTA Plan.

### How to enroll

#### Initial enrollment

If you meet the eligibility requirements, you are automatically enrolled under the BTA Plan on your date of hire, provided that you are actively at work on that date. “Actively at work” means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to travel or allows you to work.

#### Employment classification changes

You will automatically be enrolled in the BTA Plan on the day your employment classification is changed so that you become newly eligible for benefits, provided that you are actively at work on that date.

### Delayed effective date

If you are not actively at work on the day coverage normally would begin, coverage will begin when you return to being actively at work. “Actively at work” means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to travel or allows you to work.

### Changing coverage

Changing coverage is not an option under the BTA Plan. Coverage is automatically canceled when you are no longer eligible or not actively at work.

### Cost

Wells Fargo pays the entire cost for BTA coverage. You do not pay for any part of the coverage.
**Beneficiaries**

If you die in a covered accident while covered under the BTA Plan, benefits will be paid to the person or persons, trusts, or institutions you named as your beneficiary on the online Beneficiary Designation Tool.

When making a beneficiary decision, keep in mind the beneficiary may be a person, trust, charitable institution, or your estate. However, if a minor child is named as the beneficiary, the proceeds will go into a locked interest bearing account until the child turns age 18. If a guardian of the child’s estate or conservator of the child’s estate has been appointed by the court, the benefits can be paid to the child’s estate. If you need to change your beneficiaries during the year, you may do so at any time by going to the Beneficiary Designation Tool on Teamworks.

**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 beneficiaries**

You may name primary and contingent 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 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 by going to the online Beneficiary Designation Tool under Benefits Tools on Teamworks. The change becomes effective on the date you update your beneficiary designation on the online Beneficiary Designation Tool.

**Payout if no surviving or designated beneficiary**

If you do not choose a beneficiary — or if all of your designated primary and contingent 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
2. Equally among your surviving biological and adopted children*
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

* 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.

**Assigning rights**

You are not permitted to assign any of your rights under the BTA Plan, including without limitation your right to designate beneficiaries.

**BTA Plan benefits**

**When BTA Plan benefits are payable**

The BTA Plan is designed to pay a benefit if you are in a “covered accident” (as defined in the “BTA coverage” section on page 8-3) and within 365 days of the covered accident any of the following happen. You:

- Die
- Become paralyzed
- Suffer the loss of limb, speech, hearing, or sight
- Are in a coma that commences within 365 days of the date of a covered accident
- Suffer brain damage

No benefits are paid if the loss is caused or contributed to by illness or any of the causes listed in the “What is not covered” section starting on page 8-9.
Death benefit amount
The death benefit under the BTA Plan is five times your covered pay with a maximum 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 is determined by the job classification code (job class code) for your position on the Wells Fargo HR Information System (HRIS).

Job class code 2
Most positions within Wells Fargo are job class code 2. For job class code 2 positions, covered pay is defined as your annual base salary. Annual base salary is your hourly rate of pay multiplied by the number of standard hours indicated on HRIS, and takes into account the number of working days each calendar year. Base salary may be expressed as an annual, monthly, or hourly amount on HRIS, but the rate is annualized for the purpose of determining your benefit under the BTA Plan. Base salary includes amounts designated as before-tax contributions you make to other Wells Fargo-sponsored benefit plans. Base salary 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).

Job class codes 1 and 5
Mortgage Consultant Participant pay category positions are generally job class code 1.

Variable Incentive Compensation (VIC) pay category positions are generally job class code 5. Variable Incentive Compensation (VIC) applies to jobs with a pay structure designed to deliver 40% or more of target cash through incentives that are paid primarily on a monthly or quarterly basis. Assignment of jobs to VIC (job class code 5 on HRIS) requires approval of Wells Fargo Enterprise Compensation.

For both job class codes 1 and 5, covered pay is defined as your benefits base. Benefits base is calculated each quarter and earnings are annualized based on base salary and incentives, incentive bonuses, and commissions paid in the last 12 months or on a combination of these factors. (In a leave of absence situation, your benefits base is frozen on the day before the day your leave begins.) These earnings are then divided by the number of months with earnings greater than $0, with a minimum covered pay of $20,000. Benefits base includes amounts designated as before-tax contributions you make to other Wells Fargo-sponsored benefit plans. Benefits base does not include some forms of compensation such as overtime pay, shift differentials, hiring and retention bonuses, noncash awards, and perquisites (such as parking, auto allowance, or commute subsidies).

Felonious assault benefit
If a covered accident, as defined by the plan, is the result of a felonious assault as described below, you are eligible for the BTA Plan’s applicable death benefit or dismemberment, paralysis, brain damage, and coma benefits. The BTA Plan will pay a benefit of 25% of the amount of coverage indicated in the “Death benefit amount” section on this page up to a maximum of $100,000, if the insured’s covered loss results from a covered accident that occurs due to another person’s actions during a felonious assault as follows:

• An actual or attempted robbery or holdup
• An actual or attempted kidnapping
• Any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred

A felonious assault is defined as an assault committed during the commission of a felony or its equivalent as defined by the laws of the jurisdiction in which the act was committed. The act must be committed by someone other than:

• You;
• A member of your immediate family (includes spouse, domestic partner, children, parents, siblings, grandparents, and grandchildren); or
• A Wells Fargo team member.

Hospital stay benefit
The BTA Plan will pay this benefit if any of the following apply:

• Proof is received that you are confined in a hospital as a result of an accidental injury sustained in a covered accident;
• This benefit is in effect on the date of the injury; and
• 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 this page; or
• $2,500.
The BTA Plan will pay this benefit on a monthly basis beginning on the fifth day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a prorated basis for any partial month of confinement. The BTA Plan will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

**Seat belt and airbag benefit**

The death benefit will be increased by an additional 25% of the amount of coverage indicated in the “Death benefit amount” section on page 8-6, not to exceed $50,000, but no less than $1,000, if a loss of life occurs due to a covered accident while properly using a seat belt in a passenger vehicle. No seat belt benefit increase is payable if the official accident report is not provided or if the report indicates that no seat belt was worn.

The death benefit will be increased by an additional 5% of the amount of coverage indicated in the “Death benefit amount” section on page 8-6, not to exceed $12,000, but no less than $1,000, if a loss of life occurs due to a covered accident while positioned in a seat protected by a properly functioning and properly deployed airbag in a passenger vehicle.

**Wheelchair benefit**

This benefit is payable when due to a covered accident, the permanent use of a wheelchair is required to be ambulatory and in order to provide wheelchair accessibility, alterations are done to your primary residence and one vehicle you use; and the alterations to your primary residence are done by a licensed contractor.

The home alteration expenses may include installing ramps, widening doors, and lowering cabinets. They may not include remodeling expenses that have no direct relationship to providing wheelchair accessibility. The BTA Plan will pay up to 25% of the amount of coverage indicated in the “Death benefit amount” section on page 8-6 up to a maximum of $50,000.

**Accident limitation**

If multiple team members traveling together are injured in the same common accident, the policy aggregate maximum is $50,000,000.

The benefit will pay no more than the policy aggregate maximum for all covered losses for all covered team members as the result of any one covered accident. If this amount does not allow all covered team members to be paid the amounts this policy otherwise provides, the amount paid will be the proportion of the covered team member’s loss to the total of all losses, multiplied by the policy aggregate maximum.
Dismemberment, paralysis, brain damage, and coma benefits

If you are in a covered accident (as defined in the “BTA coverage” section on page 8-3) and within 365 days of the covered accident you lose a limb, sight, hearing, or speech, are paralyzed, have brain damage, or if a coma commences within 365 days from the date of the covered accident while you are covered under the BTA Plan, you will receive a benefit according to the following schedule:

<table>
<thead>
<tr>
<th>Loss</th>
<th>Amount paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dismemberment</td>
<td></td>
</tr>
<tr>
<td>Both hands or both feet or sight in both eyes; speech and hearing in both ears; or any two or more such losses in any combination</td>
<td>100% of covered amount*</td>
</tr>
<tr>
<td>One hand, one foot, sight in one eye, speech, or hearing in both ears</td>
<td>50% of covered amount*</td>
</tr>
<tr>
<td>Thumb and index finger of the same hand, all four fingers of same hand, or all toes of same foot</td>
<td>25% of covered amount*</td>
</tr>
<tr>
<td>Total paralysis</td>
<td></td>
</tr>
<tr>
<td>Both upper and lower limbs (quadriplegia)</td>
<td>100% of covered amount*</td>
</tr>
<tr>
<td>Both upper or both lower limbs (paraplegia)</td>
<td>75% of covered amount*</td>
</tr>
<tr>
<td>An upper and lower limb on one side of the body (hemiplegia)</td>
<td>50% of covered amount*</td>
</tr>
<tr>
<td>One upper or lower limb (uniplegia)</td>
<td>50% of covered amount*</td>
</tr>
<tr>
<td>Brain damage</td>
<td></td>
</tr>
<tr>
<td>Brain damage resulting from a covered accident</td>
<td>100% of covered amount*</td>
</tr>
<tr>
<td>Coma</td>
<td></td>
</tr>
<tr>
<td>A coma resulting from a covered accident</td>
<td>1% of covered amount*</td>
</tr>
<tr>
<td>(1% will be paid monthly, continuing for 11 consecutive months, with the remaining balance paid as a lump sum on the 12th month)</td>
<td></td>
</tr>
</tbody>
</table>

* Covered amount is equal to 5 times covered pay, not to exceed $2,000,000.

Covered losses, total paralysis, brain damage, and coma are defined as follows:

- Loss of a hand or foot means complete severance through or above the wrist or ankle joint.
- Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye, or the field of vision must be less than 20 degrees.
- Loss of speech means a loss of speech continuing for six consecutive months, after which a physician must determine the loss to be entire and irrecoverable.
- Loss of hearing means a loss of hearing continuing for six consecutive months, after which a physician must determine the loss to be entire and irrecoverable.
- Loss of a thumb and index finger of the same hand or four fingers of the same hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
- Loss of toes means complete severance through the metatarsal phalangeal joint.
- Paralysis or paralyzed means total loss of use of a limb. A physician must determine the loss of use to be complete and irreversible.
- Severance means the complete and permanent separation and dismemberment of the part from the body.
- Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least five days, and persist for 12 consecutive months after the date of the accidental injury.
- Coma means a profound state of unconsciousness that resulted directly and solely due to a covered accident and from which you are not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a covered injury, unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that covered accident.
**Other BTA Plan provisions**

The following provisions apply to death, dismemberment, paralysis, brain damage, and coma benefits resulting from a covered accident:

- Benefits are paid for any covered loss that occurs within 365 days following the date of the covered accident.
- Benefits are paid if a coma commences within 365 days of the covered accident.

**Exposure and disappearance coverage**

Benefits are paid if you suffer a covered loss that results directly from and solely due to a covered accident during the course of a Wells Fargo authorized business trip that causes you unavoidable exposure to the elements and is a direct result of a covered accident independent of other causes.

The BTA Plan will presume that the covered loss sustained by you for such loss is loss of life if:

- An aircraft or other vehicle in which you were traveling on business for which coverage is provided under a covered accident disappears, sinks, or is wrecked; and
- 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; or
  - 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; or
- Not incidental to the business trip, and not at the expense of Wells Fargo.

**War risk business travel coverage**

War risk coverage provides benefits for covered accidents caused by war or acts of war worldwide when in a country other than the United States and war occurs. The following countries are also excluded from these benefits: Afghanistan, Algeria, Burkina Faso, Burundi, Central African Republic, Cote d’Ivoire, Democratic Republic of the Congo, Egypt, Eritrea, Ethiopia, Guinea, Iran, Iraq, Libya, Madagascar, Mali, Nigeria, North Korea, Pakistan, Somalia, South Sudan, Sudan, Syria, Tajikistan, Yemen, and Zimbabwe.

**Terrorist act business travel coverage**

Benefits will be paid for a covered accident due to a terrorist act sustained while traveling on business except to, from, and within: Afghanistan, Algeria, Burkina Faso, Burundi, Central African Republic, Cote d’Ivoire, Democratic Republic of the Congo, Egypt, Eritrea, Ethiopia, Guinea, Iran, Iraq, Libya, Madagascar, Mali, Nigeria, North Korea, Pakistan, Somalia, South Sudan, Sudan, Syria, Tajikistan, Yemen, and Zimbabwe.

You are covered from an accident caused by an “act of terrorism” if sustained on the premises of Wells Fargo.

Terrorist act means a politically or socially motivated act of violence carried out by an individual or group of persons who may or may not be operating on behalf of a sovereign state with the intent to change political or social policy. A terrorist act does not include any act of violence carried out by a branch of the armed forces.

**What is not covered**

The BTA Plan will not pay benefits for any loss caused or contributed to by:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Infection, other than infection occurring in an external accidental wound or from accidental food poisoning;
- Participation in hazardous activities such as: scuba diving; bungee jumping; skydiving; hang gliding; ballooning; drag racing; driving a car fitted for competitive racing; aerial hunting; aerial skiing; or travel in an aircraft for the purpose of parachuting or otherwise exiting an aircraft while the aircraft is in flight except for the purpose of self-preservation;
- Service in the armed forces of any country or international authority, except the United States National Guard;
• Any nuclear reaction or release of nuclear energy. This includes the radioactive, toxic, explosive, or other hazardous or contaminating properties of radioactive matter;
• The emission, discharge, dispersal, release, or escape of any solid, liquid, or gaseous chemical or biological agent;
• Any incident related to travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger; or parachuting or otherwise exiting from such aircraft while the aircraft is in flight except for the purpose of self-preservation; or that does not have a valid Certificate of Airworthiness; or that is not flown by a pilot with a valid license to operate that aircraft; or which is owned, leased, controlled, or chartered by Wells Fargo; or in a device used for:
  – Testing or experimental purposes;
  – Or by any military authority;
  – Travel or designed for travel beyond the earth’s atmosphere;
  – Crop dusting, spraying, or seeding;
  – Fire fighting;
  – Sky diving;
  – Hang gliding;
  – Pipeline or power line inspection;
  – Sky writing;
  – Aerial photography or exploration;
  – Racing, endurance tests, stunt or acrobatic flying; or
  – 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; or
• Poison, gas, or fumes.

Claims and appeals

Filing a claim
The following steps describe how a claim is filed and processed:

1. You, your beneficiaries, or the executor of your estate should contact Team Member Care (formerly known as the HR Service Center) as soon as possible after your death or after you sustain an injury or loss.
2. You, your beneficiaries, or the executor of your estate (as applicable) should submit a claim form and a completed physician’s statement to the address below within 31 days of the date of the covered accident.

   Benefit Operations – Survivor Services
   100 W. Washington Street, 16th Floor
   MAC S4101-162
   Phoenix, AZ 85003

3. For a death claim, proof of death (including a required 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.
4. MetLife processes your claim. If approved, payment is made to you, your designated beneficiaries, or your estate.
5. 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.
BTA Plan claim initial determination, denials, and appeals

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 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

When any claim is denied in whole or in part, you or your beneficiaries 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; and
- Any written comments, documents, records, or other information deemed appropriate.

MetLife’s written decision is sent directly to you or your beneficiaries within 60 days after MetLife’s receipt of the review request. If an extension is required, MetLife will notify you or your beneficiaries 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; and
- 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 BTA 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 BTA Plan, any and all questions arising from:

- Administration of the BTA claims and interpretation of all provisions of the BTA Plan
- Determination of all questions relating to participation of eligible team members and eligibility for benefits
- Determination of all relevant facts
- Determination whether the documents, records, and other information are relevant to a claim for benefits
- Determination of the amount and type of benefits to be provided to any participant or beneficiary
- Construction of all terms of the BTA 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 BTA Plan participants.

Legal action

No legal action can be taken with regard to a claim for benefits under the BTA Plan until 60 days after the date proof of death or accident (as applicable) is filed and no later than three years after the date such proof of death or accident is required.
Benefits when you’re not working

BTA coverage may never be extended to cover you when you are not working because it is applicable only as described in the “BTA coverage” section on page 8-3.

When coverage ends

Coverage under the BTA Plan ends on the date:

• Your last day of employment takes place
• You no longer meet the eligibility requirements
• You die
• The BTA Plan is discontinued or terminated*

* For information on Wells Fargo’s ability to amend, modify, or terminate the BTA Plan, see the “Future of the plans” section in “Appendix B: Important Notifications and Disclosures.”

Conversion

There is no conversion privilege for BTA coverage.
Chapter 9
Accidental Death and Dismemberment Plan

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## Contacts

<table>
<thead>
<tr>
<th>Information about Accidental Death and Dismemberment Plan provisions</th>
<th>Teamworks</th>
</tr>
</thead>
</table>
| Information about enrollment | Team Member Care (formerly known as the HR Service Center)  
1-877-HRWELLS (1-877-479-3557), option 2  
Team Member Care accepts relay service calls.  
TDD/TTY users may call 1-800-988-0161. |
| Information about premiums for the Accidental Death and Dismemberment Plan | Check your enrollment materials, or go to Teamworks. |
| Questions about claims | Metropolitan Life Insurance Company (MetLife)  
1-800-638-6420 |
| Questions about portability forms already submitted or existing ported policies | Metropolitan Life Insurance Company (MetLife)  
1-888-252-3607 |
The information in this chapter — along with that in “Chapter 1: An Introduction to Your Benefits,” “Appendix B: Important Notifications and Disclosures,” and “Appendix D: Leaves of Absence and Your Benefits” — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Accidental Death and Dismemberment Plan (the AD&D Plan).

The basics

General information
The SPD is a summary of provisions for the AD&D Plan and its underlying fully insured policy issued by Metropolitan Life Insurance Company (MetLife). For further details, contact Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, to request a copy of the Group Accident Insurance Certificate. The SPD and Group Policy Number 164933-1-G issued by MetLife, along with any policy amendments, riders, and endorsements, constitute the official plan document for this AD&D Plan. If there are differences between the SPD and the AD&D Plan policy, the AD&D Plan policy governs your rights to benefits.

The AD&D Plan is a “welfare benefit plan” under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Insurer and claims administrator
The AD&D Plan is insured by Metropolitan Life Insurance Company (MetLife). MetLife is the named fiduciary and has sole and complete discretionary authority to administer claims and interpret benefits under the AD&D Plan.

AD&D coverage
The AD&D Plan is an optional plan that you can elect to provide financial protection for you or your family if you or your covered family member is in a “covered accident” (as defined below) and within 365 days of the date of the covered accident any of the following happen. You (or your covered spouse or dependent child, if you elect family coverage):

• Die
• Become paralyzed
• Suffer the loss of limb, speech, hearing, or sight
• Are in a coma that commences within 365 days of the date of a covered accident
• Suffer from brain damage
• Suffer from an accidental injury resulting from unavoidable exposure to the elements

A “covered accident,” as used throughout this SPD, is defined as a sudden, unforeseeable, external event that results directly, and independently of all other causes, in a covered injury or covered loss and meets all of the following conditions:

• Occurs while the covered person is insured under this AD&D Plan
• Is not contributed to by disease, sickness, or mental or bodily infirmity
• Is not otherwise excluded under the terms of this SPD or the AD&D Plan policy
## AD&D Plan at a glance

<table>
<thead>
<tr>
<th><strong>Who pays the premium?</strong></th>
<th>You, if you enroll</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MetLife policy number</strong></td>
<td>164933-1-G</td>
</tr>
<tr>
<td><strong>Type of ERISA plan</strong></td>
<td>Welfare benefit plan</td>
</tr>
<tr>
<td><strong>Who's eligible</strong></td>
<td>Regular and part-time team members, and their eligible dependents</td>
</tr>
<tr>
<td><strong>Who's not eligible</strong></td>
<td>Flexible team members</td>
</tr>
<tr>
<td><strong>Beneficiary</strong></td>
<td>The person, persons, trust, or institution you designated (or if none, according to the “Payout if no surviving or designated beneficiary” section on page 9-6)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>Based on the rate for the coverage level you elect</td>
</tr>
<tr>
<td><strong>Coverage effective date</strong></td>
<td>First of the month after one full calendar month of service from your date of hire or employment classification change to a benefits-eligible position, provided that you enrolled during your new hire or newly eligible enrollment period and you are actively at work on the day coverage is scheduled to begin. First day of the year if enrolling for the first time during Annual Benefits Enrollment, provided that you are actively at work on January 1.</td>
</tr>
<tr>
<td><strong>Cancel or change coverage</strong></td>
<td>Cancel or change coverage anytime by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2. Cancellations or changes are effective the first of the month following your call to Team Member Care. Coverage cannot be canceled or changed retroactively.</td>
</tr>
<tr>
<td><strong>Portability</strong></td>
<td>You may port this to an individual policy. See the “Portability” section starting on page 9-12.</td>
</tr>
<tr>
<td><strong>Coverage when you’re not working</strong></td>
<td>Coverage may continue when you are not actively at work during an approved leave of absence provided that you continue to pay premiums. See the “Benefits when you’re not working” section on page 9-12.</td>
</tr>
<tr>
<td><strong>AD&amp;D Plan death benefits</strong></td>
<td>You may choose individual coverage from the following coverage levels: $75,000; $150,000; $300,000; $600,000 If family coverage is elected, your benefit is based on the individual coverage you've elected (same choices as above), while the spouse benefit (the amount you get if your spouse or domestic partner dies) is 50% of your elected coverage amount (not to exceed $300,000), and your dependent child benefit (the amount you get if your dependent child dies) is 15% of your elected coverage amount (not to exceed $90,000).</td>
</tr>
</tbody>
</table>
Who’s eligible

Regular and part-time Wells Fargo team members and their eligible dependents as described in “Chapter 1: An Introduction to Your Benefits” are eligible to participate in the AD&D Plan.

You may not be covered under the AD&D Plan as both a team member and spouse, domestic partner, or dependent child at the same time. In the event of double coverage, only your claim as a team member will be honored if you are still a benefits-eligible team member.

How to enroll

Initial enrollment
You may elect to enroll in AD&D coverage during your designated enrollment period if you are one of the following:

• A newly hired benefits-eligible team member
• A team member who has had an employment classification change to a benefits-eligible position
• A rehired benefits-eligible team member

To enroll, access the benefits enrollment site on Teamworks at work or at home during the designated enrollment period. Refer to the “When to enroll — when benefits take effect” section in “Chapter 1: An Introduction to Your Benefits” to determine your designated enrollment period.

If you enroll during your designated enrollment period, AD&D coverage becomes effective the first of the month following one full calendar month of service provided that you are actively at work on the day coverage is scheduled to begin. For more information on the actively at work requirement, see the “Delayed effective date” section below.

Late enrollment
If you do not enroll during your designated enrollment period, you must wait until the next Annual Benefits Enrollment period to make an enrollment election. If you elect coverage during the Annual Benefits Enrollment period, your coverage will become effective the following January 1, subject to the actively at work provisions described under the “Delayed effective date” section below.

Cost
You pay premiums for your AD&D Plan coverage through after-tax payroll deductions each pay period. Wells Fargo does not contribute toward payment of the premium. The amount you pay depends on the coverage level and option you elected.

Beneficiaries
If you die in a covered accident while covered under the AD&D Plan, benefits will be paid to the person or persons, trusts, or institutions you named as your beneficiary on the online Beneficiary Designation Tool.

You will be asked to name one or more beneficiaries when you enroll. If you need to change your beneficiaries during the year, you may do so at any time by going to the Beneficiary Designation Tool on Teamworks.

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.

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.
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 beneficiaries
You may name primary and contingent 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 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 by going to the online Beneficiary Designation Tool under Benefits Tools on Teamworks. The change becomes effective on the date you updated your beneficiary on the online Beneficiary Designation Tool.

Payout if no surviving or designated beneficiary
If you do not choose a beneficiary — or if all of your designated primary and contingent 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
2. Equally among your surviving biological and adopted children*
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

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).

Assigning rights
You are not permitted to assign any of your rights under the AD&D Plan, including without limitation your right to designate beneficiaries.

AD&D Plan benefits

When AD&D benefits are payable
This AD&D policy is designed to pay a benefit if you or your covered family member is enrolled in the AD&D Plan and are in a “covered accident” (as defined in the “AD&D coverage” section on page 9-3), and within 365 days of the date of the covered accident any of the following happen. You (or your covered spouse 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 starting on page 9-10.

Felonious assault benefit
If a covered accident, as defined by the plan, is the result of a felonious assault as described below, you are eligible for the AD&D Plan’s applicable death benefit or dismemberment, paralysis, and coma benefits. The AD&D Plan will pay a benefit of 25% of the amount of coverage elected by the covered team member, 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); or
- A Wells Fargo team member.

**Hospital stay benefit**
The AD&D Plan will pay this benefit if:

- Proof is received that you or a covered dependent is confined in a hospital as a result of an accidental injury that is the direct cause of such confinement independent of other causes; and
- 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 team member; or
- $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 team member, 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 team member, not to exceed $10,000, but no less than $1,000, if loss of life occurs due to a covered accident while positioned in a seat protected by a properly functioning and properly deployed airbag in a passenger vehicle.

**Home alteration and vehicle modification**
The benefit will be increased by 10% of the amount of coverage elected by the covered team member, 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 requires home alteration or vehicle modification within one year of the date of the covered accident.

**Rehabilitation benefit**
The benefit is payable to the covered team member 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 team member 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 team member; 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; and
- Proof of death is provided and confirms the death occurred at least 100 miles from the covered team member’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; or
- 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 team member or $5,000.

The AD&D Plan may require proof of the spouse’s or domestic partner’s continued enrollment as a full-time student during the period for which a benefit is claimed.

**Child education benefits**

If you or your spouse or domestic partner dies as a result of a covered accident, the AD&D Plan will pay this additional child education benefit if the plan receives proof that:

- Enrolled as a full-time student in an accredited college, university, or vocational school above the 12th-grade level; or
- 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 a maximum of $10,000 or up to 5% of the amount of coverage elected by the covered team member.

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 team member plus 5% of the spouse or domestic partner coverage amount (50% of the coverage elected by the team member); and
- 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; or
- 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; and
- 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 team member.

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 team member plus 2% of the spouse or domestic partner coverage amount (50% of the coverage elected by the team member); and
- 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 team member’s elected coverage amount if both the team member and their covered spouse or domestic partner die within 365 days, and they die directly, and independently of all other causes, from a common accident and are survived by one or more dependent children.

“Common accident” means the same covered accident or separate covered accidents that occur within the same 24-hour period.

### Dismemberment, paralysis, brain damage, and coma benefits

If you or your covered family member is in a covered accident (as defined in the “AD&D coverage” section on page 9-3) and within 365 days of the covered accident you (or your covered spouse, domestic partner, or dependent child if you elect family coverage) lose a limb, sight, hearing, or speech, are paralyzed, have brain damage, or if a coma commences within 365 days from the date of the covered accident while you are covered under the AD&D Plan, you will receive a benefit according to the following schedule:

<table>
<thead>
<tr>
<th>Loss</th>
<th>Amount paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dismemberment</strong></td>
<td>100% of covered amount*</td>
</tr>
<tr>
<td>Both hands or both feet or sight in both eyes; speech and hearing in both ears; or any two or more such losses in any combination</td>
<td>100% of covered amount*</td>
</tr>
<tr>
<td>One hand, one foot, sight in one eye, speech, or hearing in both ears</td>
<td>50% of covered amount*</td>
</tr>
<tr>
<td>Thumb and index finger of the same hand, all four fingers of same hand, or all toes of same foot</td>
<td>25% of covered amount*</td>
</tr>
<tr>
<td><strong>Total paralysis</strong></td>
<td>100% of covered amount*</td>
</tr>
<tr>
<td>Both upper and lower limbs (quadriplegia)</td>
<td>100% of covered amount*</td>
</tr>
<tr>
<td>Both upper or both lower limbs (paraplegia)</td>
<td>75% of covered amount*</td>
</tr>
<tr>
<td>An upper and lower limb on one side of the body (hemiplegia)</td>
<td>50% of covered amount*</td>
</tr>
<tr>
<td>One upper or lower limb (uniplegia)</td>
<td>50% of covered amount*</td>
</tr>
<tr>
<td><strong>Brain damage</strong></td>
<td>100% of coverage amount*</td>
</tr>
<tr>
<td>Brain damage resulting from a covered accident</td>
<td>100% of coverage amount*</td>
</tr>
<tr>
<td><strong>Coma</strong></td>
<td>1% of coverage amount*</td>
</tr>
<tr>
<td>A coma resulting from a covered accident</td>
<td>1% of coverage amount* (1% will be paid monthly, continuing for 11 consecutive months, with the remaining balance paid as a lump sum on the 12th month)</td>
</tr>
</tbody>
</table>

*Covered amount is equal to the coverage level that you elected ($75,000, $150,000, $300,000, or $600,000). If family coverage is elected, your covered amount is equal to the coverage level you’ve elected, while the covered amount for your spouse or domestic partner is half of your elected coverage level (not to exceed $300,000), and the covered amount for your dependent child is 15% of your elected coverage level (not to exceed $90,000).
Covered losses, total paralysis, brain damage, and coma are defined as follows:

- Loss of a hand or foot means complete severance through or above the wrist or ankle joint.
- Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye, or the field of vision must be less than 20 degrees.
- Loss of speech means a loss of speech continuing for six consecutive months, after which a physician must determine the loss to be entire and irrecoverable.
- Loss of hearing means a loss of hearing continuing for six consecutive months, after which a physician must determine the loss to be entire and irrecoverable.
- Loss of a thumb and index finger of the same hand or four fingers of the same hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
- Loss of toes means complete severance through the metatarsal phalangeal joint.
- Paralysis or paralyzed means total loss of use of a limb. A physician must determine the loss of use to be complete and irreversible.
- Severance means the complete and permanent separation and dismemberment of the part from the body.
- Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least five days, and persist for 12 consecutive months after the date of the accidental injury.
- Coma means a profound state of unconsciousness that resulted directly and solely due to a covered accident and from which the covered person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a covered injury, unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that covered accident.

Other AD&D Plan provisions

The following provisions apply to death, dismemberment, paralysis, and coma benefits, resulting from a covered accident:

- Benefits are paid if death, dismemberment, or paralysis occurs within 365 days following the date of the covered accident.
- Benefits are paid if a coma commences within 365 days of the covered accident.

War risk coverage

War risk coverage provides benefits for covered accidents caused by war or acts of war worldwide when in a country other than the United States and war occurs. The following countries are also excluded from these benefits: Afghanistan, Algeria, Burkina Faso, Burundi, Central African Republic, Cote d’Ivoire, Democratic Republic of the Congo, Egypt, Eritrea, Ethiopia, Guinea, Iran, Iraq, Libya, Madagascar, Mali, Nigeria, North Korea, Pakistan, Somalia, South Sudan, Sudan, Syria, Tajikistan, Yemen, and Zimbabwe.

Terrorism coverage

A terrorist act is considered a felony. Please refer to the “Felonious assault benefit” section starting on page 9-6.

What is not covered

The AD&D Plan will not pay benefits for any loss caused or contributed to by:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound or from food poisoning;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Service in the armed forces of any country or international authority, except the United States National Guard;
- Any incident related to travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger; or travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight; or parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation; or travel in an aircraft or device used:
  - For testing or experimental purposes;
  - By or for any military authority; or
  - 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.

Claims and appeals

Filing a claim
The following steps describe how a claim is filed and processed:

1. You, your beneficiary, or the executor of your estate should contact Team Member Care (formerly known as the HR Service Center) as soon as possible after sustaining an injury or loss.
2. You, your beneficiary, or the executor of your estate (as applicable) should submit a claim form and a completed physician’s statement to the address below within 31 days of the date of the covered accident.

   Benefit Operations – Survivor Services
   100 W. Washington Street, 16th Floor
   MAC S4101-162
   Phoenix, AZ 85003

3. For a death claim, proof of death (including a required 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.
4. MetLife processes your claim. If approved, payment is made to you, your designated beneficiary, or your estate.
5. MetLife may require additional documents to make a determination of payment. MetLife will make these requests directly to you, your beneficiary, or your estate.

AD&D Plan claim initial determination, denials, and appeals
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 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

When any claim is denied in whole or in part, you or your beneficiaries 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 or your beneficiaries request a review, include the following:
• The reason you or your beneficiaries believe the claim was improperly denied; and
• Any written comments, documents, records, or other information deemed appropriate.
MetLife’s written decision is sent directly to you or your beneficiaries within 60 days after MetLife’s receipt of the review request. If an extension is required, MetLife will notify you or your beneficiaries 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; and
- 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 AD&D 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 AD&D Plan, any and all questions arising from:

- Administration of the AD&D claims and interpretation of all provisions of the AD&D Plan
- Determination of all questions relating to participation of eligible team members and eligibility for benefits
- Determination of all relevant facts
- Determination of the documents, records, and other information that is relevant to a claim for benefits
- Determination of the amount and type of benefits to be provided to any participant or beneficiary
- Construction of all terms of the AD&D 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 AD&D Plan participants.

**Legal action**

No legal action can be taken with regard to a claim for benefits under the AD&D Plan until 60 days after the date proof of death or accident (as applicable) is filed and no later than three years after the date such proof of death or accident is required.

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**Benefits when you’re not working**

You must continue paying the premiums to maintain AD&D coverage while you are on a leave of absence. If coverage is canceled due to nonpayment of premiums while you are on an approved leave of absence, you must wait until the next Annual Benefits Enrollment period to reenroll. Coverage will begin on the first day of the plan year following Annual Benefits Enrollment, provided that you are actively at work on the day coverage is scheduled to begin. (See “Appendix D: Leaves of Absence and Your Benefits” for more information.)

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**When coverage ends**

Coverage under the AD&D Plan ends on the last day of the month in which:

- Your last day of employment takes place
- 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.)
- The AD&D Plan is discontinued or terminated*

* For information on Wells Fargo’s ability to amend, modify, or terminate the AD&D Plan, see the “Future of the plans” section in “Appendix B: Important Notifications and Disclosures.”

Coverage under the AD&D Plan will also end if you stop paying the required premiums.

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

Team members, covered spouses or covered domestic partners, and covered dependents may elect to port AD&D coverage to an individual policy when the coverage, or any portion of the coverage, ends. Situations that allow you or your covered dependents to port to an individual policy include:

- Your Wells Fargo employment is terminated.
- You retire.
- You no longer meet eligibility requirements.
- Your covered dependents no longer meet eligibility requirements.
- The AD&D Plan terminates.

How porting works

Porting works as follows:

- The ported policy is a standard AD&D policy; therefore, the ported policy may not include all of the benefits of your coverage through the AD&D Plan and may exclude conditions that are covered under the AD&D Plan. Contact MetLife for details. The ported policy is not part of the AD&D Plan and is not part of any employee benefit plan sponsored by Wells Fargo.
- You and all of your covered dependents may port a minimum of $25,000 of coverage in increments of $1,000, up to your current coverage amount but not to exceed $250,000.
- Premiums for the ported policy are at current MetLife ported rates and are based on age and amount of coverage.
- Your porting application and first premium must be sent to MetLife within 31 days after the termination of coverage. Coverage takes effect, subject to payment of the first premium, on the later of:
  - The date coverage under the Wells Fargo AD&D Plan terminates
  - The date you apply for ported coverage

How to apply

Upon termination of group coverage through Wells Fargo, you should receive information directly from MetLife regarding portability of coverage. If you do not receive this information within 14 days, contact MetLife at 1-888-252-3607.

You must complete the portability form and mail it with the first premium payment to MetLife within 31 days from the date group coverage ends through Wells Fargo.
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Chapter 10
Short-Term Disability Plan

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<td>TDD/TTY users may call 1-800-988-0161.</td>
</tr>
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<td><a href="mailto:wellsfargo@libertymutual.com">wellsfargo@libertymutual.com</a></td>
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</table>
The information in this chapter — along with that in “Chapter 1: An Introduction to Your Benefits,” “Appendix B: Important Notifications and Disclosures,” and “Appendix D: Leaves of Absence and Your Benefits” — constitutes the Summary Plan Description (SPD) and the Plan Document for the Wells Fargo & Company Short-Term Disability Plan (the STD Plan) that covers eligible Wells Fargo team members.

The basics

General information
The Short-Term Disability (STD) Plan provides short-term disability coverage on a self-insured basis and is classified as a “welfare benefit plan” under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The STD Plan provides you with short-term disability benefits if you have a medically certified health condition and are unable to perform some or all of your job duties for more than seven consecutive calendar days (the “STD waiting period”). (Please review the “Medically certified health condition definition” section on page 10-7.) 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.

Generally, STD benefits replace either 65% or 100% of your covered pay for up to 26 weeks (your STD waiting period of the first seven consecutive days counts toward the 26 weeks), based on your completed years of service. (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.

Claims administrator
The STD Plan is self-insured, and Liberty Life Assurance Company of Boston (Liberty) is the claims administrator providing administrative claims services. Liberty has full discretionary authority to administer and interpret the STD Plan.

Who’s eligible

Eligible team members
You are eligible for the STD Plan if you are a regular or part-time Wells Fargo team member as described in “Chapter 1: An Introduction to Your Benefits.”

Ineligible team members
You are not eligible to participate in the STD Plan if you are:

- Classified as a flexible team member.
- An employee of an affiliate not participating in the STD Plan.
- An employee who is classified as an international team member.
- 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.)

Cost
Wells Fargo pays the entire cost of your coverage under the STD Plan.

How to enroll
You are automatically enrolled in the STD Plan if you are one of the following:

- A newly hired benefits-eligible team member
- A team member who has had an employment classification change to a benefits-eligible position
- A rehired benefits-eligible team member
When coverage begins

New hire or newly eligible
For benefits-eligible team members, STD coverage begins the first of the month following one full calendar month of service, subject to the requirement that you be actively at work on your first day of coverage. If you are not actively at work the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a benefits-eligible 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 a team member as a result of the acquisition or merger.

Rehired team members
If you are rehired into a benefits-eligible position within the six-month period following your termination date, your STD coverage begins on your rehire date provided that you were covered by the STD Plan at the time of your termination. If you had not yet completed one full calendar month of service at the time of your termination, your STD coverage will begin on the first of the month following one full calendar month of service after your rehire, subject to the requirement that you be actively at work on your first day of coverage as described below.

If you are rehired into a benefits-eligible position after the six-month period following your termination date, your STD coverage will begin on the first of the month following one full calendar month of service after your rehire, subject to the requirement that you be actively at work on your first day of coverage as described below.

In either case, if you are not actively at work the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a benefits-eligible position. For more information, see the “Actively at work definition” section on this page.

If you are a benefits-eligible Wells Fargo retiree rehired on or after January 1, 2011, the STD eligibility waiting period is waived, and your STD coverage begins on your first day of active employment in a benefits-eligible position.

Employment classification changes
If you become eligible for STD coverage as a result of an employment classification change, your coverage becomes effective the first of the month following one full calendar month of service in your new employment classification. You must also be actively at work the day coverage begins. If you are not actively at work the day coverage would normally begin, your coverage will begin when you return to being actively at work and complete at least one full workday in a benefits-eligible position. For more information, see the “Actively at work definition” section on this page.

If you change employment classification from regular or part-time to flexible, 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, an observed holiday, or PTO.

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 or an authorized leave during which eligibility for STD Plan participation continues (see the “Leave of absence” section on page 10-5)
- The day you have received the maximum amount of STD benefits for the same or related health condition that caused you to go on Medical Leave as shown in the “STD benefits schedule” on page 10-10
- The day you begin a Military Leave, Job Search Leave, unpaid Administrative Leave, or Salary Continuation Leave
- The day you die
- The day the STD Plan is discontinued or terminated

For information on Wells Fargo’s ability to amend, modify, or terminate the STD Plan at any time and for any reason, see the “Future of the plans” section in “Appendix B: Important Notifications and Disclosures.”
Coverage when you’re not working

**Leave of absence**

Eligibility for STD coverage continues during the following types of leaves of absence:

- **Medical Leave**, provided that:
  1. You were eligible to participate in the STD Plan as of your last day worked.
  2. You have not received the maximum amount of STD benefits as shown on the “STD benefits schedule” on page 10-10.
- **Workers’ Compensation Leave**
- **Family Leave**
- **Paid Administrative Leave**
- **Personal Leave**

You are not eligible for STD coverage during a Military Leave, Job Search Leave, unpaid Administrative Leave, or a Salary Continuation 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 10-14.

**Wells Fargo provides the Texas Injury Benefit Plan, rather than Workers’ Compensation, for Texas team members who have a work-related injury or illness. For Texas team members, references to “Workers’ Compensation” shall mean the “Wells Fargo Texas Injury Benefit Plan.”

How to file a claim for STD benefits

**1. Call your supervisor**

If you are unable to work your regular work schedule, you must speak to your supervisor immediately. If you are unable to personally speak to your supervisor, have someone else make the call. You don’t need to share any medical information with your supervisor, but you should keep in regular contact with him or her about your leave status, including any extension of your leave, work restrictions, return to work date, and requested accommodations, if any.

If you are aware of an impending leave because of a planned medical procedure, you should provide your supervisor with at least 14 days’ advance notice.

**2. Call Liberty**

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 Liberty. There are two ways to file your claim for STD benefits:

1. **Call our Claims Administrator, Liberty, at 1-877-HRWELLS (1-877-479-3557), option 2.**

2. **File online at Liberty Mutual at https://www.mylibertyconnection.com. First-time users will need to establish a username and password by following the prompts on the screen. The company code for Wells Fargo is “wells.”

You may report your claim for disability benefits up to 14 days in advance of the date your leave is to begin. Proof of your disability is required for all claims and must be received by Liberty within the designated time frame described in the “Proof of your disability” section starting on page 10-7. Proof may include medical records, test results, or hospitalization records as Liberty deems necessary. If Liberty has not received valid medical proof of your disability within the designated time frame, your request for STD benefits will be denied. For more information, see the “STD benefits schedule” on page 10-10 and the “Proof of your disability” section on page 10-7.

If your health condition is due to a work-related illness or injury, you must contact a Risk & Insurance Management Representative by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, to file a separate Workers’ Compensation claim.

If you return to work, and within 30 calendar days you miss work again because of a recurrence of your medically certified health condition, immediately contact all of the following:

- Your supervisor
- Liberty, at 1-877-HRWELLS (1-877-479-3557), option 2

For more information, see the “Recurrent condition” section on page 10-9.

A claim for STD benefits and Workers’ Compensation for the same condition will be coordinated. Workers’ Compensation is considered the primary source of income continuation if you have a health condition that is payable under both Workers’ Compensation and the STD Plan. STD benefits will be reduced by your Workers’ Compensation benefits. (See the “Deductible sources of income” section on page 10-11 for more information.) Claims for STD benefits are reviewed independent of claims for Workers’ Compensation benefits.
3. Get the forms you need

The forms referenced below are available by calling Liberty, at 1-877-HRWELLS (1-877-479-3557), option 2.

Please include your Liberty claim number and your first and last name on all correspondence sent to Liberty. This allows Liberty to expedite the review of any correspondence concerning your request for STD benefits.

Required forms

Complete the Authorization to Obtain and Release Information form and fax it to Liberty at 1-866-214-7839 or mail it to the following address:

Liberty Life Assurance Company of Boston
Disability Claims
PO Box 7208
London, KY 40742-7208

To expedite the processing of your claim, Liberty may need to contact your physician to obtain medical information concerning your disability. Your physician cannot share medical information concerning your disability unless the authorization is on file with Liberty. Failure to provide a completed authorization form may result in the denial of your claim for STD benefits.

In some cases, your health care provider may need to complete the Attending Physician Statement and fax it to Liberty at 1-866-214-7839 or mail it to:

Liberty Life Assurance Company of Boston
Disability Claims
PO Box 7208
London, KY 40742-7208

The Attending Physician Statement is important to Liberty's review of your request for STD benefits when Liberty is not successful in obtaining medical information from your physician telephonically. Your physician's failure to provide the Attending Physician Statement when required may result in the denial of your claim for STD benefits.

4. Provide valid medical information

The medical information you provide in support of your claim must be accurate. If the information is not accurate or the signature of the health care provider is not valid as determined by Liberty or the plan administrator, your claim for STD benefits will be denied or discontinued, you will be disqualified from participating in the STD Plan, and you may be subject to further disciplinary action, including termination of employment.

5. Timely action required

Your STD benefits payments will be denied or discontinued if you or your health care provider does not supply, by the due date, all of the information about your condition requested by Liberty.

How the STD Plan works

STD waiting period

You may be eligible for STD benefits after you complete the STD waiting period. The 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.

You are required to use accrued, unused Paid Time Off (PTO) or paid sick time (PST), if applicable, during the STD waiting period for any scheduled work hours you miss. If you do not have accrued PTO or PST available, the STD waiting period will be unpaid unless your business group allows team members to use unaccrued PTO from their current year's unaccrued PTO. If this is the 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 (the parental leave is not part of the STD Plan; see Teamworks for more information), you do not need to use PTO or PST to cover the STD waiting period because you will be receiving 100% pay under the parental leave for that waiting period time frame. However, if you are not the primary caregiver and defer your parental leave to a later date or the parental leave policy does not apply to you, you are required to otherwise meet the STD waiting period as in the paragraph described above.

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 covered 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. For more information, see “5. Timely action required” on page 10-6.
• 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 of your own job as regularly scheduled for longer than the STD waiting period.

**Pregnancy**
You may be eligible for six or eight weeks of STD benefits after you deliver your baby and satisfy the STD waiting period (see the “STD waiting period” section on page 10-6 for more information). You may also be eligible for a parental leave, which would allow you to receive benefits under that policy beginning on the date of the delivery (parental leave is not part of this STD Plan). See the “How the STD Plan benefit coordinates with Wells Fargo-sponsored parental leave benefits” section on page 10-11 for more information.

You may be eligible for STD benefits before or after delivery based on the medical information provided to Liberty. 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 preventing you from performing the essential duties of your regular job. For more information, see the “Qualifying for STD benefits” section starting on page 10-6.

**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 Liberty or the plan administrator, 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 Liberty receives requested medical proof of your disability, which may include medical records, test results, and hospitalization records, within the designated time frame. If Liberty 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.
You can file a claim for STD benefits beyond 90 days following your date of disability if you can show both of the following:

- It was not reasonably possible to give timely written proof of your claim for Short-Term Disability benefits because of a hospitalization or because of a serious medical condition that rendered you totally incapacitated.
- Medical information supporting your claim for STD benefits satisfactory to Liberty or the plan administrator was provided as soon as was reasonably possible.

**Benefits determination**

**Approvals**

Approval of a claim for STD benefits is based on one or more of the following:

- Medical information provided by your approved care provider or providers
- Professional opinions of other care providers as designated by Liberty or the plan administrator
- Other criteria as specified in this STD Plan Summary Plan Description

You will receive written notification of the status of your claim for STD benefits within 45 days of Liberty’s receipt of your claim for STD benefits. If your claim for STD benefits is approved, the letter will state the expected duration of your STD benefits, when updated medical information is due, or when benefits will stop. Approvals are retroactive to the first day you are medically certified to miss work after the STD waiting period. For more information, see the “Claims and appeals” section starting on page 10-13.

**Denials**

If Liberty 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 10-13.

After a claim for STD benefits has been denied, if you continue to remain out of work due to your medically certified health condition (the health condition that was the basis for your denied claim) or for any other reason, you are not eligible to file a subsequent claim for STD benefits for this same health condition (excluding pregnancy) while you remain out of work even if you are on an approved leave of absence. (However, you have the right to appeal the denied claim; see the “Filing an appeal” section starting on page 10-14.) Liberty 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**

Liberty 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 Liberty 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 Liberty and your supervisor informed with updates about your leave status.

**Confidentiality of medical information**

Medical information about your diagnosis, treatment plan, and care provider will be kept confidential by Liberty, unless your file is released to the plan administrator or its designee in connection with an appeal. Liberty may release medical information to a third-party vendor or to your treating providers as it pertains to your claim for disability benefits. Such information will not be disclosed to your supervisor without your consent or made part of your personnel file.

With your written consent, information may be shared with Wells Fargo as it pertains to administration of your leave (Leave Disability Management), as it pertains to your return to work (Accommodations Management), or as it pertains to mental health referrals (Employee Assistance Consulting). Information about your dates of leave, eligibility for STD benefits, return to work dates, work restrictions, requested accommodation, or any combination thereof may be provided to your supervisor or Human Resources consultant and may be noted in your personnel file.

**Medical evaluations and treatment plans**

Your approved care provider should establish a detailed treatment plan to assist you in your recovery and continue to provide proof of your disability to Liberty. Before you can return to work, Liberty and your supervisor must receive a signed confirmation of your release to return to work from your approved care provider. Your release must explain any requested accommodations or work restrictions.

**Independent medical examinations**

Liberty 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. Liberty 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**
Liberty 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. Liberty pays for the evaluations.

**On-site medical case management**
Liberty may contract with an on-site medical case manager to assist you and your Liberty disability case manager to facilitate your timely return to work. The on-site medical case manager may accompany you to medical appointments, review and coordinate care and treatment, visit your home and workplace, and communicate with your care providers, supervisor, Human Resources consultants, and your Liberty disability case manager. You are required to cooperate with on-site medical case management to continue receiving STD benefits.

**Recruent 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.

**If you are disabled and working (reduced work schedule)**
A reduced work schedule is an accommodation provided to you by your supervisor, Wells Fargo Accommodations Management, or both if you have proof of a disability that prevents you from working 100% of your predisability standard hours as documented by your health care provider. All accommodations must be reviewed and approved by your supervisor, Wells Fargo Accommodations Management, or both.

STD benefits may be paid in combination with the earnings you receive while on a reduced work schedule based on the applicable percentages and time periods described in the “STD benefits schedule” on page 10-10. 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.

**Reduced work schedule STD pay examples**
- Example 1 for team members 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 a team member working 40 hours per week
    - At a 65%* STD benefit level, your maximum STD benefit would be $650 biweekly
  - If, on the reduced work schedule, you work 20 hours per week and earn $500 biweekly (for your hours worked)
    - The remaining eligible STD benefit would be $150 biweekly (the $650 STD maximum benefit minus the $500 biweekly pay for hours worked)

* Your eligible STD benefit amount is based on the “STD benefits schedule” noted on page 10-10.
• Example 2 for team members 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 a team member 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 for up to 26 weeks based on your completed years of service, as shown in the table below. For information on covered pay, see the “Covered pay” section starting on this page.

Note: Your STD waiting period of the first seven consecutive days counts toward the 26 weeks.

<table>
<thead>
<tr>
<th>Completed years of service</th>
<th>Weeks at 100% of covered pay*</th>
<th>Weeks at 65% of covered pay*</th>
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<tr>
<td>Less than 1 year</td>
<td>None</td>
<td>25 weeks</td>
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<td>1 – 3 years</td>
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<tr>
<td>4 – 6 years</td>
<td>7 weeks</td>
<td>18 weeks</td>
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<tr>
<td>7 – 9 years</td>
<td>13 weeks</td>
<td>12 weeks</td>
</tr>
<tr>
<td>10 or more years</td>
<td>25 weeks</td>
<td>None</td>
</tr>
</tbody>
</table>

* After completion of the STD waiting period (see the “STD waiting period” section on page 10-6 for more information).

Completed years of service

For STD benefits, your completed years of service are measured from your corporate hire date as explained on Wells Fargo’s HR Information System (HRIS) 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 on the Wells Fargo HR Information System (HRIS).

Job class code 2

Most positions within Wells Fargo are job class code 2. For job class code 2 positions, covered pay is defined by your annual base salary. Annual base salary is your hourly rate of pay (including geographical differentials, if applicable) multiplied by the number of standard hours indicated on Wells Fargo’s HRIS 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.

Job class codes 1 and 5

Variable Incentive Compensation positions

Variable Incentive Compensation (VIC) applies to jobs with a pay structure designed to deliver 40% or more of target cash through incentives that are paid primarily on a monthly or quarterly basis. Assignment of jobs to VIC requires approval of Wells Fargo Enterprise Compensation. For VIC team members (positions assigned job class code 5 on Wells Fargo’s HRIS and Payroll System), covered salary is your benefits base as indicated on that system based on the most recent quarterly earnings calculation. (Generally, quarterly calculations are completed the first Sunday after the first payday of every quarter. For example, in July, the first payday was July 14, 2017, so the calculation ran on July 16, 2017. The amount of covered pay would be updated
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 determined by the Internal Revenue Code’s annual compensation limit for qualified retirement plans, but is subject to change by the federal government at its discretion.

**Wells Fargo Mortgage Consultant Participant positions**

For Mortgage Consultant Participant team members (positions assigned a job class code 1 on Wells Fargo’s HRIS and Payroll System), covered salary is your benefits base as indicated on that system up to a maximum determined by the Internal Revenue Code’s annual compensation limit for qualified retirement plans, but is subject to change by the federal government at its discretion.

When team members 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 team member returns to work (including on a part-time basis or reduced work schedule). The excess (if any) net commission credit is given to the team member. In no case will the team member earn less than the calculated STD benefit each month while on leave.

**STD benefit amount**

STD benefits are generally based on your covered pay 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 benefit coordinates with Wells Fargo-sponsored parental leave benefits**

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.

Your benefits under the parental leave policy supplement 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), your concurrent parental leave benefit will be reduced accordingly, and you will only receive 35% of your pay under the parental leave policy to provide for 100% of your predisability pay for the time period that the STD Plan benefit runs concurrent to the parental leave.

You will never receive more than 100% of your predisability covered pay. For more information about the parental leave policy, refer to Teamworks or call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 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
- Workers’ Compensation benefits attributed to lost income, including a settlement awarded to you
- Automobile accident wage replacement income
- Salary Continuation Leave
- Income while you are working under an approved reduced work schedule
- Any income received for disability under a government compulsory benefit or program that provides for loss of time from your job due to your disability, whether such payment is made directly by the plan or program or through a third party (including but not limited to Social Security disability, retirement, and dependent’s benefits, but excluding survivor benefits)
- Third-party recovery for loss of income by judgment, settlement, or otherwise, including recovery amounts you may receive from future earnings as permitted by state law

If you work in a state or commonwealth with a mandatory disability program (currently California, Hawaii, New Jersey, New York, Puerto Rico, and Rhode Island), it is your responsibility to apply for statutory benefits.

If you are on an approved STD claim and you become eligible for salary continuation pay benefits under the Wells Fargo & Company Salary Continuation Pay Plan, your STD benefits will be coordinated with your salary continuation pay so that you do not receive more than 100% of your predisability covered salary. Generally, employment is terminated at the end of a Salary Continuation Leave. However, if your Salary Continuation Leave ends and you continue to qualify...
for STD benefits, you will continue to receive STD benefits until you are no longer eligible. After your STD benefits end, your employment will be terminated. If you are on a Salary Continuation Leave before the date you become disabled, you will not be eligible for STD or LTD coverage.

Payment of STD benefits
Once the plan administrator receives notification from Liberty that your STD claim meets the criteria for approval, all STD benefits will be paid through the Wells Fargo regular biweekly payroll system. Your regular benefit deductions will continue to be taken from your STD benefits in accordance with the provisions of the other Wells Fargo plans in which you participate. In some instances, your health benefit deductions may not be included in your disability check. In these cases, you may be billed later. You should review each payment to ensure that the appropriate deductions have been taken for your health benefits.

Recovery of overpayment
If you receive excess STD benefits because you receive income from one of these deductible sources described in the “Deductible sources of income” section starting on page 10-11 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 or any Long-Term Disability Plan benefits by the amount overpaid.

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 26 weeks (the first seven consecutive calendar days of which are 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 Liberty. For more information, see the “Medical evaluations and treatment plans” section on page 10-8.
- Cooperate with on-site medical case management.
- Follow the prescribed treatment plan.
- Follow approved work restrictions or accommodations.
- Return to work when medically certified to do so.
- Accept the same or equivalent offer of employment within your medical restrictions.
- Begin working for wage or profit if not under an approved reduced work schedule.
- The date your weekly earnings exceed 80% of your predisability covered pay.
In addition, your STD benefits may end if your employment is terminated for any reason.

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 based on your covered pay in effect on the day before the initial date of your disability. For example, if you are a team member 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 $1,346.15 biweekly rate. To calculate the survivor benefit, take this amount and multiply it by 10 to get $13,461.60. In this example, $13,461.60 would be paid to your designated beneficiary at the time of your death. The survivor benefit will be reduced by any overpayment of STD benefits that may exist. Taxes will not be withheld from your survivor benefit. Your estate or the benefit recipient may, however, be required to pay additional taxes to the state or federal government. Consult a tax advisor for tax information related to your survivor benefit.

You will be asked to name one or more beneficiaries when you enroll in benefits, using the online Beneficiary Designation Tool. If you need to change your beneficiaries during the year, you may do so at any time by going to the Beneficiary Designation Tool on Teamworks.

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
2. Equally among your surviving biological and adopted children*
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

* 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.

Exclusions

Not all conditions are covered by the STD Plan. Benefits will not be paid for any condition that is caused by or results from:

- Your commission or attempted commission of any criminal act, including but not limited to an assault, battery, felony, or any combination thereof
- Injuries you sustain or illness contracted while you are performing services for, or receiving compensation from, the military
- A cosmetic surgery or elective procedure, unless the surgery or procedure is:
  - Performed in connection with, or as a result of, a covered injury, accident, or illness in which the surgery or procedure is required due to reconstruction or medical necessity
  - Gender reassignment-related services (pre- and postsurgery)
  - 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 10-5. It is important to note that there is a claims filing deadline. You may report your claim for disability benefits up to 14 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 from the first day of the STD waiting period.

Claim determinations, determination extension, and requests for additional information

After you submit a claim for STD benefits, Liberty 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, Liberty may have up to two additional extensions of 30 days each to provide you such notification.

If Liberty 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 Liberty’s notice requesting additional information and an extension until Liberty receives the requested information does not count toward the time period that Liberty 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 Liberty.

Content of the claim determination notice

As noted above, 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 must 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 Liberty 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 Liberty 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 Liberty’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 Liberty. You or your duly authorized representative must sign your appeal request. It should be sent to Liberty by U.S. mail to the following address:

Liberty Life Assurance Company of Boston
Disability Claims
PO Box 7208
London, KY 40742-7208

The address for filing an appeal is also noted in Liberty’s adverse benefit determination letter.

Your appeal must be submitted in writing to Liberty 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, Liberty 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 Liberty. 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 Liberty 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 Liberty 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 the claims administrator (Liberty). Liberty 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.

Liberty 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 Liberty for final consideration in the appeal review process (such information must be submitted before the final determination is due). Liberty 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 Liberty, 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 Liberty’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, Liberty may have up to an additional 45 days to provide you with notification of the final decision. If such an extension is needed, Liberty 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 Liberty.

If Liberty 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, Liberty must receive your written request for documents, records, and other information no later than 120 days after Liberty sends you its final written appeal decision.

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 10-13 for more information). Any suit for benefits must be brought within one year from the date the final appeal determination was issued by Liberty.
# Chapter 11
## Long-Term Disability Plan

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# Contacts

| Information about claims       | Liberty Life Assurance Company of Boston  
|                               | 1-866-213-2937 |
| Information about the Long-Term Disability (LTD) Plan | Teamworks  
|                               | Team Member Care (formerly known as the HR Service Center)  
|                               | 1-877-HRWELLS (1-877-479-3557), option 2  
|                               | Team Member Care accepts relay service calls. TDD/TTY users may call 1-800-988-0161. |
| Information about premiums for the LTD Plan | Check your enrollment materials, or go to Teamworks. |
The information in this chapter — along with that in “Chapter 1: An Introduction to Your Benefits,” “Appendix B: Important Notifications and Disclosures,” and “Appendix D: Leaves of Absence and Your Benefits” — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Long-Term Disability Plan (the LTD Plan) that covers eligible Wells Fargo team members.

**The basics**

**General information**

The Long-Term Disability (LTD) Plan is designed to provide continuing income if you are disabled for more than 26 weeks. The SPD and Group Disability Income Policy issued by Liberty, along with any certificates, policy amendments, riders, and endorsements, constitute the official plan documents for the LTD Plan. If there are any differences between the SPD and the LTD Plan policy, the LTD Plan policy governs your right to benefits. The LTD Plan is insured by Liberty Life Assurance Company of Boston and is classified as a “welfare benefit plan” under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Generally, under Basic LTD coverage, LTD benefits replace up to 50% of your covered pay.

If you have elected Optional LTD coverage (Optional LTD provides an additional 15% of your covered pay), LTD benefits replace up to a combined total of 65% of your covered pay, per year. The maximum covered pay for Basic LTD and Optional LTD is $500,000. (See the “Covered pay” section on page 11-6.)

LTD benefits coordinate with other disability income benefits that you may be entitled to (see the “Deductible sources of income” section on page 11-7). Many of the terms used in this chapter have been specifically defined for the LTD Plan by Liberty Life Assurance Company of Boston (Liberty). Some terms are defined throughout the chapter; others are defined at the end in the “Other LTD definitions” section starting on page 11-16.

**Insurer and claims administrator**

The LTD Plan is insured by Liberty Life Assurance Company of Boston (Liberty). Liberty has the discretionary authority to administer claims and interpret benefits under the LTD Plan.

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**Who’s eligible**

**Eligible team members**

You are eligible for Basic LTD coverage and Optional LTD coverage if you are a regular or part-time Wells Fargo team member as described in “Chapter 1: An Introduction to Your Benefits.”

**Ineligible team members**

You are not eligible to participate in the LTD Plan if you are:

- Classified as a flexible team member.
- An employee of an affiliate not participating in the LTD Plan.
- A person whom Wells Fargo classifies as an independent contractor or any other status by which you are not treated as a common-law employee of Wells Fargo for purposes of withholding taxes, regardless of your actual status. (This applies to all periods of such service of an individual who is subsequently reclassified as an employee, whether the reclassification is retroactive or prospective.)
- A person whom Wells Fargo has classified as a legacy Wachovia team member with a date of disability prior to January 1, 2010.
- A person whom Wells Fargo classifies as an international team member.

**Cost**

**Basic LTD**

Wells Fargo pays the cost of your Basic LTD coverage.

**Optional LTD**

If you choose to enroll for Optional LTD coverage, you are responsible for the full cost of the additional coverage, and premiums will be deducted from your pay each pay period. Deductions will be taken on an after-tax basis. Premiums are based on your age and covered pay. If your age or covered pay changes, your premium will be adjusted accordingly. If you are approved for LTD benefits under your Optional LTD coverage, your Optional LTD premiums will be waived for the duration of your approved LTD claim.
How to enroll

Initial enrollment

Basic LTD
You are automatically enrolled for Basic LTD coverage if you are one of the following:
- A newly hired benefits-eligible team member
- A team member who has had an employment classification change to a benefits-eligible position
- A rehired benefits-eligible team member

Optional LTD
If you are eligible for Basic LTD coverage as described above, you may enroll for Optional LTD coverage; see the “How to enroll” section in “Chapter 1: An Introduction to Your Benefits.”

Late enrollment
You may also enroll at any point during the year with completed Evidence of Insurability as approved by Liberty. For more information and to request an Evidence of Insurability form, call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2.

Annual Benefits Enrollment
If you did not enroll in Optional LTD coverage during your initial enrollment period, you may enroll in Optional LTD coverage during the Annual Benefits Enrollment period. Generally, coverage is effective the following January 1. However, you must be actively at work before your coverage is effective. For a definition of actively at work, refer to the “Actively at work definition” section on page 11-5. However, a preexisting condition exclusion may apply to your Optional LTD coverage. (See the “Preexisting conditions” section on page 11-6.)

When coverage begins

New hires or newly eligible team members
For benefits-eligible team members, Basic LTD coverage — and Optional LTD coverage, if elected — begins on the first of the month after one full calendar month of service. 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 benefits-eligible position. For more information, see the “Actively at work definition” section on page 11-5.

If you were previously employed by a company that was acquired by or merged with Wells Fargo, certain transition rules may apply to your eligibility for Basic and Optional LTD coverage under the LTD Plan when you first become a team member as a result of the acquisition or merger.

Rehired team members
If you are rehired into a benefits-eligible position within the six-month period following your termination date, your coverage will be reinstated at the same level that was in effect on your termination date.

If you are rehired into a benefits-eligible position after the six-month period following your termination date, Basic LTD coverage — and Optional LTD coverage, if elected during your designated enrollment period — begins the first of the month after one full calendar month of service if you are actively at work on the date coverage is scheduled to begin.

In either case, if you are not actively at work on the date coverage normally starts, your LTD coverage will not begin until you return to being actively at work and complete at least one full workday. You may be considered actively at work if it is your normally scheduled day off, on an observed holiday, or on Paid Time Off (PTO). For more information, see the “Actively at work definition” section on page 11-5.

Employment classification changes
If you change your employment classification and become newly eligible for benefits, Basic LTD coverage — and Optional LTD coverage, if elected during your designated enrollment period — begins the first of the month after one full calendar month of service if you are actively at work on the date coverage is scheduled to begin.

If you are not actively at work on the date coverage normally starts, your LTD coverage will not begin until you return to being actively at work and complete at least one full workday. You may be considered actively at work if it is on your normally scheduled day off, on an observed holiday, or on PTO. For more information, see the “Actively at work definition” section on page 11-5.

If you change employment classification from regular or part-time to flexible, your LTD coverage will end as of the classification change date. If you are receiving LTD benefits as of your classification change date, you will continue to receive LTD benefits until you are released to return to work or you are no longer approved for LTD benefits.

Reinstatement after a leave of absence
For information, see the “Coverage when you’re not working” section on page 11-11.
Actively at work definition

“Actively at work” means you are performing your customary duties during your regularly scheduled hours at a Wells Fargo location, or at places Wells Fargo requires you to work or travel, or allows you to work. Actively at work also includes any normally scheduled days off work, an observed holiday, or PTO.

How the LTD Plan works

LTD waiting period

While you are covered by the LTD Plan, you may be eligible for LTD benefits after you complete the LTD waiting period. The waiting period is the 26-week period of continuous or partial disability as measured from your initial date of disability. Time spent working a reduced work schedule due to a disability may apply toward the 26-week waiting period if you are unable to earn more than 80% of your predisability covered pay as a result of your disability. To qualify for LTD benefits, you must be receiving continuous appropriate care and treatment from a doctor during the LTD waiting period. For more information, see the definitions of “appropriate care and treatment” on page 11-16 and “Doctor” on page 11-16.

Generally, periods of continuous and partial disability separated by a return-to-work period of 30 days or less are added together for purposes of determining the 26-week LTD waiting period. Only the days you are disabled will count toward your waiting period. However, if you are released to return to work and more than 30 days have passed before you become disabled again, you will have to begin a new waiting period.

Premiums

If you have enrolled for Optional LTD coverage, you must continue to pay your monthly premium until your LTD benefits begin in order to continue your LTD coverage. After LTD benefits begin, your monthly premiums for Optional LTD coverage stop and any premiums you paid for the time after the LTD waiting period will be refunded to you. If you don’t continue paying premiums during the period until your LTD benefits begin (including the LTD waiting period), your Optional LTD coverage will terminate.

Qualifying for benefits

To qualify for LTD benefits, you must:

• Be covered by the LTD Plan on the initial date of your disability.

• Be disabled as defined by the LTD Plan for more than 26 weeks.

• Continue to pay premiums for Optional LTD coverage during the LTD waiting period and until your claim for LTD benefits is approved.

• Receive approval for LTD benefits by Liberty.

  – Receive appropriate care and treatment by a doctor on a continuous basis. For more information, see the definition of “appropriate care and treatment” on page 11-16.

  – Provide proof that you are disabled under the terms of the LTD Plan. For more information, see the definition of “proof of your disability” on page 11-16.

Definition of disability

“Disabled” or “disability” means that, due to sickness (including a mental illness), pregnancy, or accidental injury, both of the following apply:

• During your LTD waiting period and the next 24-month period, you are unable to perform the material and substantial duties of your own occupation for any employer in your local economy. (For more information, see the definitions of “own occupation” on page 11-16 and “local economy” on page 11-16.)

• After this 24-month period, you are unable to perform the material and substantial duties of any occupation for which you are reasonably qualified, taking into account your training, education, experience, and predisability pay for any employer.

Definition of partial disability

“Partial disability” or “partially disabled” means that, as a result of injury or sickness, you are able to do either of the following:

• Perform one or more, but not all, of the material and substantial duties of your own occupation or any occupation on a part-time basis.

• Perform all of the material and substantial duties of your own occupation or any occupation on a part-time basis.

To be considered partially disabled, you must earn between 20% and 80% of your covered pay. (See the definition of “any occupation” on page 11-16.)

Your loss of pay must be a direct result of your sickness, pregnancy, or accidental injury. Economic factors, including but not limited to recession, job obsolescence, pay cuts, and job sharing, will not be considered in determining whether you meet the loss of earnings test. If you are a team member whose occupation requires a license, loss of your license for any reason does not, in itself, constitute a disability.
Preexisting conditions

The LTD Plan does not pay benefits for a disability that was contributed to, was caused by, or results 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 coverage.
- The disability begins in the first 12 months after your effective date of coverage, and you have been treated for the disability during the three months before the effective date.

However, even though your condition meets the definition of a preexisting condition under the LTD Plan, you may be eligible for LTD benefits if you were previously covered under the LTD Plan of a company acquired by Wells Fargo (a “prior LTD plan”).

If you were covered by a prior LTD plan on the day immediately before the date your coverage under the Wells Fargo LTD Plan became effective, your “effective date” for purposes of the preexisting condition exclusion described above will be the effective date of your coverage under the prior LTD plan. This means that if your continuous coverage under the prior LTD plan and this LTD Plan is more than 12 months as of your initial date of disability, you will not be subject to the preexisting condition exclusion. If approved, your LTD benefit will be limited to the lesser of the benefit amounts of your prior LTD plan and your current Basic LTD coverage, Optional LTD coverage, or both.

Recurrent disabilities

If you are receiving LTD benefits, recover from your disability, and then have a recurrent disability due to the same or related condition, Liberty will treat your disability as part of your prior claim, and you will not have to complete another LTD waiting period, if:

- You were continuously covered under the LTD Plan for the period between your prior claim and your recurrent disability.
- Your recurrent disability occurs within six months of the end of your prior claim.

Your recurrent disability will be subject to the same terms of the LTD Plan as your prior claim, including the covered pay used to determine the LTD benefit that was paid to you as a result of the prior claim.

After six months

Any disability that recurs after six months from the date your prior claim ended will be treated as a new claim and will be subject to all of the provisions of the LTD Plan, including a new LTD waiting period.

LTD Plan benefits

Covered pay

Your LTD benefit is based on your covered pay 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 on the Wells Fargo HR Information System (HRIS). Covered pay is converted from an annual amount (not exceeding $500,000 per year) to a monthly amount, subject to the exceptions noted below.

Job class code 2

Most positions within Wells Fargo are job class code 2. For most participants (except as described below), covered pay for LTD coverage is defined as your annual base salary plus eligible certified incentive compensation paid in the last 12 months before the initial date of your disability converted to a monthly amount. To avoid fluctuation, premiums are based on annual base salary plus certified incentive compensation paid in the prior calendar year.

Annual base salary

Annual base salary is your hourly rate of pay multiplied by the number of standard hours indicated on HRIS. Base salary may be expressed as an annual, monthly, or hourly amount on the system; however, the rate is annualized for the purpose of determining your benefit under LTD coverage. Base salary includes amounts designated as before-tax contributions you make to other Wells Fargo benefit plans. 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 commute subsidies).

Eligible certified incentive compensation

Eligible certified incentive compensation includes those commissions, bonuses, and other earnings that have been certified for the LTD Plan. Certain incentive compensation plans may have caps on the amount considered certified.
Job class codes 1 and 5
If the Wells Fargo Enterprise Compensation department assigns your position a Variable Incentive Compensation (VIC) pay category or a Mortgage Consultant Participant pay category, LTD coverage defines covered pay as your benefits base indicated on HRIS, based on the most recent quarterly earnings calculation, up to a maximum of $500,000 in covered pay. (Generally, quarterly calculations are completed the first Sunday after the first payday of every quarter. For example, in July, the first payday was July 14, 2017, so the calculation ran on July 16, 2017. The amount of covered pay would be updated on the day of the calculation.) These positions are assigned job class code 5 or job class code 1 on HRIS. 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.

VIC applies to jobs with a pay structure designed to deliver 40% or more of target cash through incentives that are paid primarily on a monthly or quarterly basis. Assignment of jobs to VIC (job class code 5 on HRIS) requires approval from Wells Fargo Enterprise Compensation.

Benefit amount
LTD benefits are based on your covered pay on the day before the initial date of disability. If you are eligible for Basic LTD coverage, your gross monthly LTD benefit is 50% of your monthly covered pay up to a maximum benefit amount of $20,833 per month.

If you are enrolled for Optional LTD coverage, your gross monthly LTD benefit is generally 65%. Optional LTD coverage provides an additional 15% of your covered pay. Your total combined gross benefit will be 65% of your covered pay up to a maximum benefit amount of $27,083 per month. (See the “Covered pay” section on page 11-6.) Liberty will calculate your monthly LTD benefit. For more information, see the “Deductible sources of income” section on this page.

The minimum monthly LTD benefit is 10% of your gross LTD benefit or $100, whichever is greater. The minimum monthly benefits will not apply if you are in an overpayment situation or are receiving income from employment (unless the income is from your participation in an approved rehabilitation program or an approved part-time return-to-work program). For more information, see the “Recovering LTD benefit overpayments” section on page 11-12 and the “If you are disabled and working” section starting on page 11-9.

Deductible sources of income
Your gross LTD benefit will be automatically reduced by the amount of income you are eligible to receive from other sources, including but not limited to:

- Social Security benefits (including disability, retirement, and dependents’ benefits but excluding survivor benefits)
- Earnings from any form of employment
- Railroad Retirement Act
- Workers’ Compensation benefits
- Any state or public employee retirement or disability plan
- State disability benefits
- Any other group plan providing total disability benefits sponsored by or contributed to by Wells Fargo
- Benefits for disability, retirement, or both that you receive under a retirement plan, to the extent that such benefits are attributable to employer contributions, excluding distributions from the Wells Fargo & Company 401(k) Plan, the Wells Fargo Cash Balance Plan, and Wells Fargo nonqualified plans of deferred compensation
- Third-party recovery for loss of income by judgment, settlement, or otherwise, including recovery amounts you may receive from future earnings
- Unemployment insurance laws or programs
- Maritime maintenance and cure
- Occupational disease laws
- Any income received for disability under a government compulsory benefit or program that provides for loss of time from your job due to your disability, whether such payment is made directly by the plan or program or through a third party

If you receive deductible sources of income in a lump sum instead of in monthly payments, you must provide Liberty with satisfactory proof of the breakdown of:

- The amount attributable to lost income
- The time period for which the lump sum is applicable

You must provide information requested by Liberty on any deductible sources of income within 10 business days from the date of the award. If this information is not provided, Liberty may reduce your LTD benefit by an amount equal to the LTD benefit each month until the lump sum has been exhausted. However, if Liberty is given proof of the time period and amount attributable to lost income, Liberty will make a retroactive adjustment.
Benefit payment
LTD benefits will begin to accrue on the date following the day you complete the LTD waiting period. When Liberty determines that you are disabled under the LTD Plan, benefits will be paid monthly following completion of your LTD waiting period and benefit approval by Liberty. LTD benefits will be paid on a monthly basis thereafter. Generally, your LTD benefit payment will be sent to your home address unless you request that your payment be deposited directly in your bank account.

LTD benefit payments are based on the number of days you are disabled during each one-month period. LTD benefits due for a period of less than one month are paid at a daily rate of $\frac{1}{30}$ of the monthly LTD benefit.

Taxes on benefits
Basic LTD benefits you may be eligible to receive are considered to be taxable income. If you elected Optional LTD coverage, the premiums are paid with after-tax dollars; therefore, the Optional LTD benefits are generally not taxable income.

You may direct Liberty to withhold federal and state taxes from your LTD benefits. If no taxes are withheld, or if the amount withheld is not enough to cover the actual taxes due, you may be required to pay additional taxes. Consult a tax advisor for tax information related to your LTD benefits.

When benefits end
Your LTD benefits will stop and your claim will end on the earliest of the following:

- The end of the maximum benefit period (see the “Maximum long-term disability benefit period” table on page 11-9).
- The end of the period specified for particular conditions. For more information, see the “Limitations and exclusions” section starting on page 11-10.
- The day Liberty determines that you are no longer disabled as defined by the LTD Plan.
- The day of your death.
- The date you stop or refuse to participate in an approved rehabilitation program. For more information, see the “If you are disabled and working” section starting on page 11-9.
- The day you fail to be examined or evaluated at regular intervals by your treating providers or to attend a medical examination requested by Liberty.
- The day you fail to cooperate in the administration of your LTD claim.
- The day you are able to work in your own occupation on a part-time basis and you choose not to (see the “Own occupation” definition on page 11-16).
- The day your partial disability earnings exceed 80% of your covered pay for three consecutive months.
- The day you fail to provide Liberty with any of the following pieces of information:
  - Proof of your disability, which may include but is not limited to a completed Attending Physician’s Statement, medical records, test results, mental health records, prescription records, and any other medical information that may be needed to evaluate your claim
  - Evidence of continuing disability
  - Proof that you are under the appropriate care and treatment of a doctor throughout your disability
  - Information about deductible sources of income during your disability
  - Any other material information related to your disability that may be requested by Liberty
Maximum long-term disability benefit period

<table>
<thead>
<tr>
<th>If you are disabled when you are</th>
<th>Your maximum LTD benefit period is the greater of the duration shown below, or your normal retirement age as defined by the Social Security Administration on the date your disability starts</th>
</tr>
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<tbody>
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<td>To age 65</td>
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<td>68</td>
<td>15 months</td>
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<tr>
<td>69 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>

Survivor benefit

If you die while receiving LTD benefits, the LTD Plan pays your eligible survivor a lump sum in an amount equal to five times your net monthly LTD benefit. (Liberty will first reduce the survivor benefit by any overpayment that may exist on your claim.)

To qualify for a survivor benefit, the following conditions must be met:

- You completed the LTD waiting period.
- You were eligible to receive a monthly LTD benefit at the time of your death.
- You have an eligible survivor.
- Proof of your death is provided to Liberty.
- The person making the claim is an “eligible survivor,” which means the first of the following who survives you:
  1. Your surviving spouse or domestic partner
  2. Your surviving unmarried children under age 25, in equal shares
  3. The surviving unmarried children of your spouse or domestic partner under age 25, in equal shares
  4. Your estate

Payment to a minor child may be made to an adult who submits proof satisfactory to Liberty that the adult has assumed custody and support of the child.

If you are disabled and working

Your monthly LTD benefit will be reduced by any deductible sources of income (see the “Deductible sources of income” section on page 11-7), including your wages while working under an approved rehabilitation program or an approved part-time return-to-work program (referred to as a “reduced work schedule”). Your combined LTD benefit and wages will never exceed 100% of your predisability covered pay.

During the first 12 months following your LTD waiting period, your LTD benefit will only be reduced if your LTD benefit and your earnings exceed 100% of your predisability covered pay. If the combined total is more than 100% of your predisability covered pay, the monthly LTD benefit will be reduced by the excess amount.

After the 12-month period described above, your monthly LTD benefit will be reduced by 50% of your earnings from working while disabled. Your monthly LTD benefit will be further reduced if the total amount you receive from the above sources and the deductible sources exceeds 100% of your predisability covered pay. That portion of the total amount you receive that exceeds 100% of your predisability covered pay will reduce your monthly LTD benefit.
Rehabilitation program

Effective rehabilitation can often result in returning you to productive employment. A rehabilitation program means:

- Returning to active employment on either a part-time or full-time basis in an attempt to enable you to resume gainful employment or service in an occupation for which you are reasonably qualified, taking into account your training, education, experience, and past earnings.
- Participating in vocational training or physical therapy. This must be deemed by Liberty’s rehabilitation coordinators to be appropriate.

Developing a rehabilitation program is a team effort that involves you, Wells Fargo, your doctor, and Liberty’s rehabilitation professionals. If you choose not to participate in a rehabilitation program that Liberty recommends, your LTD benefits will terminate.

Family care expense benefit

During the first 24 months following the LTD waiting period, you may be eligible for a family care expense benefit. If you are receiving LTD benefits and you work or participate in an approved rehabilitation program or reduced work schedule, you will be reimbursed for eligible family care expenses you incur with respect to each eligible family member.

An eligible family member is a person who is living with you as part of your household and who is chiefly dependent on you for support.

Eligible family care expenses are those monthly expenses incurred by you in order for you to participate in an approved rehabilitation program, up to $325 per month for each eligible family member, to provide:

- Child care for an eligible family member under the age of 13. (Child care must be provided by a licensed child care facility or other qualified child care provider.)
- Care for an eligible family member who, as a result of a mental or physical impairment, is incapable of caring for himself or herself.

Family care expenses provided by a member of your immediate family or someone living in your residence are not eligible for reimbursement.

Eligible family care expenses do not include expenses for which you are eligible for reimbursement under any other group plan or from any other source. You must provide proof to Liberty that you incurred such charges and that the eligible family member is incapable of caring for himself or herself and is chiefly dependent on you for support. The proof must be satisfactory to Liberty.

Limitations and exclusions

Limitations for particular conditions

Mental illness

If you are disabled by a mental illness (see the definition of “Mental illness” on page 11-16), the LTD Plan generally pays a maximum of 24 monthly LTD benefit payments in your lifetime unless you are disabled due to:

- Schizophrenia
- Dementia
- Organic brain disease
- Bipolar disorder

If you are confined in a hospital or institution due to a mental illness at the end of 24 monthly LTD benefit payments, LTD benefits will continue until the confinement ends. If you are not confined to a hospital or institution, but are fully participating in an extended treatment plan for the condition that caused the disability, LTD benefits will be extended for 12 months. For more information, see the definition of “Mental illness” on page 11-16.

However, in no event will monthly LTD benefits be payable longer than the maximum LTD benefit period.

Alcohol, drug, or substance abuse or dependency

If you are disabled due to alcohol, drug, or substance abuse or dependency, monthly LTD benefits are limited to 24 monthly LTD benefits during your lifetime. If you are confined in a hospital or institution due to alcohol, drug, or substance abuse or dependency, at the end of 24 monthly LTD benefit payments, LTD benefits will continue until the confinement ends. You must also be concurrently participating in an available rehabilitation program recommended by a doctor. For more information, see the “Other LTD definitions” section on page 11-16 and the “Rehabilitation program” section on this page. In no event will monthly LTD benefits be paid beyond the earlier of the date:

- The maximum LTD benefit period has been completed (see the “Maximum long-term disability benefit period” table on page 11-9).
- 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 Liberty 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 11-6.)

Coverage when you’re not working

Leaves of absence
Eligibility for LTD coverage continues during certain types of leaves of absence, including but not limited to:

- Medical Leave
- Workers’ Compensation Leave
- Family Leave
- Paid Administrative Leave

For your Optional LTD coverage to continue, you must continue to pay the monthly premiums during the 26-week LTD waiting period and until you begin receiving LTD benefits from Liberty.

For more information, see “Appendix D: Leaves of Absence and Your Benefits.”

If you discontinue paying premiums, your Optional LTD coverage will stop and you will be subject to the preexisting condition exclusion should you enroll for Optional LTD coverage in the future. However, your Basic LTD coverage will continue for as long as you continue to satisfy the eligibility requirements of the LTD Plan. Your coverage and monthly premiums for Optional LTD coverage (if you were enrolled in it) will resume if you return to work in a benefits-eligible position. If you don’t want coverage to resume automatically, you must notify Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, as soon as possible following your return to work.

Eligibility for Basic and Optional LTD coverage ends when the following types of leaves of absence begin:

- Personal Leave
- Job Search Leave
- Unpaid Administrative Leave
- Military Leave
- Salary Continuation Leave

This means that if you become disabled during one of these leaves, you will not be eligible for LTD benefits. But if your initial date of disability occurs before going on one of these leaves, you may be eligible for LTD benefits subject to the terms of the LTD Plan.

Return to work in six months or less for team members on an approved leave of absence
If you return to work within six months or less of the first day of a Personal, unpaid Administrative, Military, Job Search, or Salary Continuation Leave, your LTD coverage will be automatically reinstated at the same level of coverage you had before your leave of absence and you will not be subject to a new LTD preexisting condition exclusion.

If you don’t want coverage to resume automatically, you must notify Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, as soon as possible following your return to work.

Return to work after six months for team members on an approved leave of absence
If you return to work after six months from the first day of a Personal, Military, unpaid Administrative, or Salary Continuation Leave, you will need to contact Team Member Care (formerly known as the HR Service Center) to enroll in Optional LTD coverage. You will need to notify Team Member Care at 1-877-HRWELLS (1-877-479-3557), option 2, within 60 days from the date you return to your regularly scheduled work hours.
Claims and appeals

If you are disabled for more than 18 weeks and your doctor believes your disability will be longer than 26 weeks, you will receive instructions from Liberty for filing an LTD claim. If you have been disabled for 18 weeks or more and you have not received instructions, call Liberty at 1-866-213-2937. If it appears likely that you will continue to be disabled, file your LTD claim early to help avoid a gap in benefits.

Note: You may also become eligible for Social Security disability benefits if your disability continues for five months or more. For more information, please see the “Filing a claim for Social Security disability benefits” section on this page.

Filing an LTD claim

After you receive the necessary forms for filing a long-term disability claim, complete and return them to Liberty as instructed. To receive LTD benefits, you must provide Liberty all of the following documents:

- Proof of your disability, which may include but is not limited to a completed Attending Physician Statement, medical records, test results, mental health records, prescription records, and any other information needed in the evaluation of your claim
- Evidence of continuing disability
- Proof that you are under the appropriate care and treatment of a doctor throughout your disability
- Information about deductible sources of income
- Any other material information related to your disability that Liberty requests

In addition, you will be required to provide signed authorization for Liberty to obtain and release your financial and medical information.

Claims filing deadline

The deadline for filing an LTD claim is 90 days from the LTD benefit begin date. No LTD benefits will be payable for claims submitted more than 90 days from the LTD benefit begin date. The LTD begin date is the date of disability after you satisfy the waiting period.

However, you can request that LTD benefits be paid for late claims if you can show both of the following:

- It was not reasonably possible to give written proof of your disability during the one-year period (the one-year waiting period is defined as one year from the date of disability).
- Proof of your disability, which may include but is not limited to a completed Attending Physician Statement, medical records, test results, mental health records, prescription records, and any other information needed in the evaluation of your claim, satisfactory to Liberty was provided as soon as was reasonably possible.

Filing a claim for Social Security disability benefits

If it appears likely that you will continue to be disabled, contact your local Social Security Administration office for information about filing a claim for Social Security disability benefits. You may also contact Liberty if you have any questions or would like assistance filing for Social Security disability benefits.

Your spouse and children may also be eligible to receive Social Security disability benefits due to your own disability.

Recovering LTD benefit overpayments

Liberty has the right to recover from you any amount that it determines to be an overpayment. You are obligated to refund to Liberty any such amount.

When you apply for LTD benefits, you will be required to sign a reimbursement agreement indicating that you agree to repay all overpayments and authorizing Liberty to obtain any information relating to other income.

Liberty may recover an overpayment by:

- Reducing or offsetting against any future LTD benefits payable to you or your survivors.
- Stopping future LTD benefit payments, including minimum LTD benefit payments that would otherwise be due under the LTD Plan. In such cases, LTD benefit payments may continue when the overpayment has been recovered.
- Demanding an immediate refund of the overpayment from you; you have the right to appeal any overpayment recovery.
**LTD claim determinations, determination extension, and requests for additional information**

After you submit a claim for LTD benefits to Liberty, it will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim, except for situations requiring an extension of time because of matters beyond the control of the LTD Plan. In such cases, Liberty may have up to two additional extensions of 30 days each to provide you such notification.

If Liberty 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 Liberty’s notice requesting further information and an extension until Liberty receives the requested information does not count toward the time period Liberty is allowed to notify you of its claims decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from Liberty.

**Content of the claim determination**

As noted previously, you will receive notice of the claim determination. An adverse benefit determination is a denial of your claim in whole or in part. Adverse benefit determinations must contain a complete discussion on why the claim was denied. If you receive an adverse benefit determination, the notice will provide the following information:

- The specific reason or reasons for the adverse determination.
- Reference to the specific LTD plan provisions on which the determination is based.
- If the claim is denied because Liberty did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.
- If an internal rule, protocol, guideline, or other criterion was relied upon to make the determination, the decision will state the internal rule, protocol, guideline, or other criterion or indicate that a copy of such rule, protocol, guideline, or other criterion will be provided free of charge to you upon request.
- If the adverse determination is based on medical necessity, experimental treatment, or similar exclusion or limit, you will receive an explanation of scientific or clinical judgment for the determination, applying the terms of the LTD Plan to the claimant’s medical circumstances, or a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request.
- An explanation of the basis for disagreeing (or not) with any of the following information:
  - The views presented by the claimant of treating health care professionals or vocational professionals who evaluated you
  - The views of the medical or vocational experts whose advice was obtained in connection with the decision, whether or not relied upon
  - A Social Security disability benefit determination presented by you
- A description of the plan’s claim appeal review procedures (including the time limits applicable to such procedures) and a statement regarding your right to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended (ERISA) Section 502(a) following an adverse benefit determination on appeal.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
- Any additional information required under applicable law.

For additional information on filing an appeal under the LTD Plan, see the “Filing an appeal” section on page 11-14.
Filing an appeal

If Liberty denies your LTD claim in whole or in part, you believe you should be entitled to a different amount of LTD benefits, or you disagree with any determination that has been made reflecting your benefits under the LTD Plan, you (or your authorized representative) may appeal the decision. You (or your authorized representative) must file your appeal in writing within 180 days of the date you receive Liberty’s written adverse benefit determination of your claim, regardless of any discussions or consultations about the claim. The LTD Plan has one level of appeal, which is reviewed by Liberty. You or your duly authorized representative must sign your appeal request. It should be sent to Liberty by U.S. mail to the following address:

Liberty Life Assurance Company of Boston
Attn: [insert disability case manager’s name]
PO Box 7208
London, KY 40742-7208

The address for filing an appeal is also noted in Liberty’s adverse benefit determination letter.

Your appeal must be submitted in writing to Liberty and must include at least the following information:

• Your name
• Your claim number
• Name of the plan (that is, the Wells Fargo & Company Long-Term Disability Plan)
• Reference to the initial determination
• An explanation of why you are appealing the initial determination

As part of your appeal, you may submit any additional written comments, documents (including additional medical information), records, or other information relating to your appeal that supports your request for benefits. Upon your written request, Liberty will provide you free of charge with copies of documents, records, and other information relevant to your initial claim. A request for this information does not, however, extend the time frame you have to file your appeal.

The appeal process is your opportunity to present documentation and evidence to show that your claim for benefits is covered and payable under the LTD Plan. However, the review process does not permit you, your beneficiary, or your authorized representative to appear in person before, or meet with, anyone from Liberty. 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 Liberty 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 Liberty receives your written timely filed appeal request, it will conduct a full and fair review of your claim. The reviewer will look at the claim anew and no deference will be given to the prior denial. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination of your claim.

In addition, the person who will review your appeal will not be the same person who reviewed your claim or a subordinate of the person who made the initial decision to deny your claim (in whole or in part). If the initial denial is based in whole or in part on a medical judgment, the reviewer will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination.

Note: It is very important that you submit all of the information you want reviewed when your appeal is filed. The date the appeal is filed is the date it is received by the claims administrator (Liberty). Liberty 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.

Liberty will provide you, free of charge, with copies of any new or additional evidence or rationale considered, relied upon, or generated in connection with the claim appeal review as soon as possible and sufficiently in advance of the date on which the notice of final benefit determination is required to be provided to you (to give you a reasonable opportunity to respond prior to that date). After you receive the information, if you feel there is a need, you may submit additional information to Liberty for final consideration in the appeal review process (such information must be submitted before the final determination is due). Liberty 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 Liberty, it (or its designated representative) will review your appeal and notify you of its decision to approve or deny your appeal. This notification will be mailed to you within a reasonable period of time, but no later than 45 days after Liberty’s receipt of your written request for appeal review, except for situations requiring an extension of time because of matters beyond the control of the LTD Plan. If an extension is required, Liberty may have up to an additional 45 days to provide written notification of the final decision. If such an extension is needed, Liberty will notify you before the expiration of the initial 45-day period, state the reason or reasons why such an extension is needed, and state when it will make its determination. You will have 45 days to provide any requested information from the date you receive the notice from Liberty.

If Liberty denies the claim on appeal in whole or in part (an adverse benefit determination), it will send you a final written decision. The notification of the decision will provide the following information:

• The specific reason or reasons why your appeal was denied.

• Reference to the specific LTD Plan provision or provisions on which the denial was based.

• If the appeal was denied because sufficient information was not provided, a description of the additional information needed and an explanation as to why it was needed.

• An explanation of the basis for disagreeing (or not) with any of the following information:
  – The views presented by the claimant of treating health care professionals or vocational professionals who evaluated you
  – The views of the medical or vocational experts whose advice was obtained in connection with the decision, whether or not relied upon
  – A Social Security disability benefit determination presented by you

• If an internal rule, protocol, guideline, or other criterion was relied upon to make the determination, the decision will state the internal rule, protocol, guideline, or other criterion, or indicate that a copy of such rule, protocol, guideline, or other criterion will be provided free of charge to you upon request.

• If the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of scientific or clinical judgment for the determination, applying the terms of the LTD Plan to the claimant’s medical circumstances, or a statement that such explanation of the scientific or clinical judgment will be provided free of charge upon request.

• A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

• If applicable, a description of the plan’s additional claim appeal review procedures (including the time limits applicable to such procedures).

• A statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA.

• A description of any applicable contractual limitations period and its expiration date.

• Any additional information required under applicable law.

If you wish to receive copies of documents, records, and other information relevant to the final appeal decision, Liberty must receive your written request for documents, records, and other information no later than 120 days after Liberty sends you its final written appeal decision.

Legal action
With limited exceptions for violations of claim procedure regulations, no legal action can be filed against the plan until the LTD Plan’s claims and appeals procedures have been exhausted (refer to the “Claims and appeals” section starting on page 11-12 for more information).

Any suit for benefits must be brought within three years from the date the final appeal determination was issued by Liberty.
When coverage ends

Your eligibility to be enrolled for LTD coverage ends on the earliest of the following dates:

- The day Wells Fargo terminates the LTD Plan or the applicable coverage option under the LTD Plan*
- The day your last day of employment takes place
- The day you transfer to an ineligible employment classification or position
- The day you begin a Military Leave, Job Search Leave, unpaid Administrative Leave, Personal Leave, or Salary Continuation Leave
- The day you stop paying for Optional LTD coverage (Optional LTD only)
- The first of the month following the day you request to drop your Optional LTD coverage (Optional LTD only)
- The day you die

If your initial date of disability occurs before your LTD coverage ends, you may be eligible for LTD benefits if your LTD claim is approved.

* For more information on Wells Fargo’s ability to amend, modify, or terminate the LTD Plan at any time and for any reason, see the “Future of the plans” section in “Appendix B: Important Notifications and Disclosures.”

Other LTD definitions

Any occupation

“Any occupation” means any occupation for which you are or may become reasonably fitted by training, education, experience, age, and physical and mental capacity.

Appropriate care and treatment

“Appropriate care and treatment” means medical care and treatment that meet all of the following:

- It is generally accepted by physicians to cure, correct, limit, treat, or manage the disabling condition.
- It is received from a doctor whose license and qualifications are suitable for treating your disability.
- It is necessary to meet your basic health needs and is of demonstrable medical value.
- It is consistent in type, frequency, and duration of treatment with relevant guidelines of national medical, research, and health care coverage organizations and governmental agencies.
- It is consistent with the diagnosis of your condition.

Doctor

“Doctor” means a person (who is not related to you) who is legally licensed to practice medicine and is practicing within the terms of his or her license, including a licensed Ph.D. psychologist, or other licensed mental health practitioner who is not related to you. A licensed medical practitioner will be considered a doctor if:

- The provider is licensed to practice medicine in the jurisdiction where such services are provided.
- The care and treatment provided by the practitioner is within the scope of his or her license.
- The provider or practitioner is not related to you.

Local economy

“Local economy” means the geographic area surrounding your place of residence that, as defined by the U.S. Office of Management and Budget’s listing of Metropolitan Statistical Areas, offers reasonable employment opportunities. It is an area within which it would be reasonable for you to travel to secure employment. If you move from the place you resided on the date you became disabled, Liberty may look at both that former place of residence and your current place of residence to determine local economy.

Material and substantial duties

“Material and substantial duties” means responsibilities that you are normally required to perform at your own occupation and that cannot be reasonably eliminated or modified.

Mental illness

A “mental illness” is defined as a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause of the mental illness. You must be receiving appropriate care and treatment for your condition by a mental health doctor.

Own occupation

“Own occupation” means the activity that you regularly perform and that serves as your source of income on the initial date of your disability. It is not limited to the specific position you held with your employer. It may be a similar activity that could be performed with your employer or any other employer in your local economy.

Proof of your disability

“Proof of your disability” may include but is not limited to a completed Attending Physician’s Statement, medical records, test results, mental health records, prescription records, and any other medical information that may be needed in the evaluation of your claim.
Chapter 12
Salary Continuation Pay Plan

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The information in this chapter — along with that in “Chapter 1: An Introduction to Your Benefits” and “Appendix B: Important Notifications and Disclosures” (only the information in the “Your rights under ERISA,” “Plan sponsor,” “Agent for service,” “Plan year,” “Participating employers,” and “Future of the plans” sections) — constitutes the Summary Plan Description (SPD) effective as of April 1, 2017, for the Wells Fargo & Company Salary Continuation Pay Plan (the “Plan”) that covers eligible Wells Fargo team members.

The basics

There may be times when displacements or job changes are necessary for business reasons. If this happens, affected participants are given advance notice whenever possible and are provided assistance in locating other suitable positions; in the case of team members who are returning from a Medical Leave with no position and no job reinstatement protection, assistance is provided to help find or be placed into a suitable position. The Plan is designed to provide compensation to assist eligible team members 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. The Plan was originally effective July 1, 1999 and it has been amended and restated several times with effective dates of April 1, 2002, January 1, 2009, July 1, 2009, January 1, 2010, June 1, 2010, July 1, 2010, January 1, 2013, and August 1, 2016. It was most recently amended for participants who receive written notice of a qualifying event occurring on or after April 1, 2017 (the “effective date”). (For more information about qualifying events, see the “Qualifying events” section starting on page 12-5.) No person is authorized to make promises regarding benefits under the Plan except as provided in the Plan.

Who’s eligible

Eligible team members

You are eligible to participate in the Plan if you are classified as a regular or part-time Wells Fargo team member on a Wells Fargo U.S.-based payroll system and you are not working in a Wells Fargo “Interim” position. (See the “Interim positions” section below.)

Interim positions

Due to business needs related to market conditions, Wells Fargo has identified certain positions as “Interim” positions that can last up to 18 months (including any time working in the position as a flexible team member). If you are in one of these Interim positions as determined by Wells Fargo, you will become eligible to participate in the Plan on the first day of the calendar month following your transfer to a regular or part-time position that is not an Interim position.

Ineligible individuals

You are not eligible to participate in this Plan if you are:

- **Classified as a flexible team member.** “Flexible team members” are team members who may work regularly on a flexible schedule but are not classified as regular or part-time, may work any number of hours on given projects, may fill in when needed regardless of the hours, are on call, or may 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 that 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, by action of the Chairman, 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 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.)
Disqualifying events

Even if you are a participant in the Plan, you become immediately ineligible for salary continuation pay and a Salary Continuation Leave under this Plan if:

• You are a 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 Wells Fargo and another company and the severance or separation pay under such agreement or arrangement is greater than the salary continuation pay that would be due under this Plan, as determined by the plan administrator.

• You are party to an agreement or other arrangement that provides severance or separation pay less than the salary continuation pay that would be due under this Plan and you do not timely waive such benefits in a manner prescribed by the plan administrator.

• 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 severance, change in control, or salary continuation pay.

• You accept employment with Wells Fargo or an Affiliate because you have located a new position through the job posting process or on your own, or you become registered with an Affiliate.

• You fail to cooperate with Wells Fargo’s “retain” efforts after being advised either verbally or in writing that your position will be eliminated but before you begin the Salary Continuation Leave.

• Wells Fargo enters into a Corporate Transaction (including but not limited to, a transaction where another company contractually agrees to acquire all or any portion of the assets, stock, or operations of Wells Fargo or some other business arrangement between the parties) and pursuant to the terms of the Corporate Transaction, the Participant is presented a Qualifying Employment Offer or Qualifying Employment Offer terms of employment, whether or not the Participant accepts or declines the Qualifying Employment Offer or continued employment with the other company.

• For purposes of this Plan, the terms of a Qualifying Employment Offer include a job offer at a location that is not a material change in your commute distance and that provides credit for previous service, an annual salary at least equal to your salary at the time of the transaction that contains at least the following: health insurance, a retirement plan/savings plan, and a policy providing paid time away. For more information, see the “Substantial position change” section on page 12-5.

• Your employment with Wells Fargo is terminated before you complete your Notice Period (for any reason except due to your death).

• You commence employment outside of Wells Fargo or an Affiliate before you complete your Notice Period. For more information, see the “Notice Period” section on page 12-8.

• You are discharged for a reason other than a qualifying event (including but not limited to poor performance, violation of Wells Fargo’s Code of Ethics and Business Conduct, or Wells Fargo’s employment policies), whether or not you had already received notice of a qualifying event, or you are on Salary Continuation Leave. For more information, see the “Qualifying events” section starting on page 12-5.

• On the date you would otherwise be eligible to receive written notice of a qualifying event under the Plan, you are on a leave of absence and meet either 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 a Qualified Medical Leave. For more information, see the “Qualified Medical Leave” section on page 12-6.

  – You have exhausted the specifically defined statutory period of time for job reinstatement under state or federal laws applicable to your leave (for example, five years or longer during a time of war or due to incapacity under USERRA or a similar state statute, or three years under Oregon Workers’ Compensation statute or other similar state statute).

• You voluntarily request or accept a change in your position that would otherwise be a substantial position change.

• You qualify for salary continuation pay but you refuse or fail to comply with the terms of the Agreement and Release. For more information, see the “Agreement and general release” section on page 12-8.
Qualifying events

The following events may qualify you for salary continuation pay under the Plan — a position elimination, a Substantial Position Change, a displacement as a result of Wells Fargo’s placement of a team member returning from Military Leave, or you or Wells Fargo do not identify a new position following your: (1) repatriation from a Wells Fargo-sponsored international assignment, (2) completion of a company-sponsored rotational assignment, or (3) return from a Qualified Medical Leave and you are unable to find or be placed into a suitable position. If you think you qualify for salary continuation 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 starting on page 12-10.

Position elimination

A position elimination is an elimination of your job or any other form of a reduction in force initiated by Wells Fargo. You may be eligible for salary continuation pay if your position is eliminated.

Substantial position change

Subject to the “Ineligible changes” described in the “Ineligible changes” section on page 12-6, you may be eligible for salary continuation pay under the Plan if management changes your existing position or your position is eliminated and you are transferred to or offered another position resulting in one of the following changes:

- A material change in your work location where all of the following occur:
  - The distance between your previous work location and the new work location exceeds 20 miles (one way).
  - The resultant commute (mileage) from home to the new work location exceeds your commute to the previous work location (one way).
  - The resultant commute from home to the new work location exceeds 40 miles (one way).
- A material reduction of more than 15% in either:
  - Your covered pay, which is your rate of pay multiplied by your standard hours as indicated on the Wells Fargo HR Information System (HRIS), if your pay category is Salaried (job class code 2).
  - Your annual base salary rate (if applicable) as indicated on the Wells Fargo HRIS, if your pay category is Variable Incentive Compensation (VIC) (job class code 5), provided that your prechange annual base salary rate is not maintained at the prechange level for a six-month transition period.

If your pay category is VIC (job class code 5) or Mortgage Consultant Participant (job class code 1), no other compensation changes or changes in covered pay other than the limited events described above will be deemed to be a substantial position change under the Plan. If you are informed that changes in your position represent a substantial position change and you accept the position changes, you will not be eligible for salary continuation benefits under the Plan.

Displacements related to USERRA job reinstatement efforts

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides team members returning from Military Leave with certain rights and protections. You may be eligible for salary continuation pay under the Plan if management places a team member returning from Military Leave in your position and either: (1) management does not reassign you to another position or (2) management reassigns you to another position that qualifies as a substantial position change. For more information about substantial position changes, see the “Substantial position change” section on this page.

Displacements related to completed international assignments or rotational assignments

Following your repatriation from a Wells Fargo-sponsored international assignment or completion of a Wells Fargo-sponsored rotational assignment, you may be eligible for salary continuation pay under the Plan if management does not place you in a new position or identifies a new position that qualifies as a substantial position change under the Plan. You will be expected to cooperate with Wells Fargo’s “retain” efforts to place you in a new position. For more information about substantial position changes, see the “Substantial position change” section on this page.
Qualified Medical Leave

A Qualified Medical Leave is a Medical Leave certified by Wells Fargo or its leave administrator that has continued beyond applicable statutory job reinstatement periods and that 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 and you are not offered or placed in a position with Wells Fargo, you may be eligible for salary continuation pay under the Plan.

Ineligible changes

You are not eligible for salary continuation pay for other types of position changes, 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
- A change in the amount of your draw
- 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 of a telecommuting agreement

How the Plan works

If you are an eligible participant, you have a qualifying event, and you sign, in a timely manner, the Agreement and Release (the Agreement) provided to you in your displacement packet*:

- You will be placed on a Salary Continuation Leave and begin receiving salary continuation pay when your Notice Period ends. For more information, see the “Notice Period” section on page 12-8.
- You will continue to receive biweekly payments on Wells Fargo’s regularly scheduled paydays for as long as you are eligible, unless you notify Wells Fargo’s Displacement Services in writing that you have begun a benefits-eligible job with another employer, in which case your remaining salary continuation pay will be paid to you in a lump sum. For more information, see the “Salary continuation pay” section on page 12-7.
- As set forth in the Salary Continuation Pay Benefit Schedule, the duration of your payments will be determined by your completed years of service when the Notice Period ends, and will not take into account time worked on a STAR program assignment.
- The amount of your biweekly payments will be determined by your Covered Pay at the end of the Notice Period (excluding any STAR program assignments). You will receive these payments on a biweekly schedule unless you begin a benefits-eligible position with another employer and you request a lump-sum payout of the remaining portion of your salary continuation pay.
- You will be eligible to continue participation in some of Wells Fargo’s benefit plans, as defined by the terms of each plan, during the Salary Continuation Leave.
- In accordance with Wells Fargo’s retain philosophy, resources will be available to assist you in finding new opportunities within Wells Fargo.
- Deductions that are authorized by you and by law will be taken from your payments.
- Your salary continuation pay will be integrated with the amount of any state-mandated disability benefits, Wells Fargo-sponsored disability benefits, and Workers’ Compensation paid to you during the Salary Continuation Leave so that you do not receive more than 100% of your predisability covered pay.

* If you are on an employer sponsorship or certain student visa determined by the Plan Administrator to be eligible for salary continuation pay as described in this sentence, the bullet points above do not apply because you are only eligible for a lump-sum severance payment as described in the first paragraph on the next page.
If you are an eligible participant on an employer sponsorship or certain student visa determined by the plan administrator to be eligible for a lump-sum severance payment, you have a qualifying event, and you sign, in a timely manner, the Agreement and Release (the Agreement) provided to you in your displacement packet, the following terms apply:

• The amount of your lump-sum severance payment will be determined by your Covered Pay at the end of the Notice Period.

• Salary continuation pay is considered to be taxable income. Wells Fargo will withhold all applicable taxes and deductions required by federal, state, local, and other laws or regulations.

• Your employment will end following completion of the Notice Period.

Salary continuation pay
The length of time you will be eligible for salary continuation pay is based on your completed years of service as described on this page.

Covered pay
For most participants, the Plan defines “covered pay” as your base salary (referred to in the Plan document as the “Annual Salary Rate”) up to a maximum annual base salary of $350,000. These positions are assigned a job class code 2 on the Wells Fargo HRIS.

Base salary is your hourly rate of pay multiplied by the number of standard hours indicated on the Wells Fargo HRIS as of the end of the 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 annual base salary. Weekly base salary includes amounts designated as before-tax contributions to Wells Fargo’s team member benefit plans. Base salary 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, base salary may be expressed as an annual, monthly, or weekly amount.

If Wells Fargo’s Enterprise Compensation Department assigns your position a Mortgage Consultant Participant pay category (job class code 1), your covered pay is your Annual Benefits Base 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 corporate hire date on the Wells Fargo HRIS as of the end of your Notice Period (and will not take into account time worked on a STAR program assignment, if any). Only data obtained by Wells Fargo or an Affiliate in any prior transaction conversion, and accounted for in your corporate hire date at Wells Fargo’s discretion, will be calculable.

The “Salary continuation pay schedule” on page 12-8 is used to determine the duration of salary continuation pay that should be paid to you if you qualify under the terms of the Plan. If you are placed on a Salary Continuation Leave, you will receive salary continuation pay for the number of weeks indicated in the “Salary continuation pay schedule” on page 12-8. The duration is based on your completed years of service as of the end of the Notice Period (but will not take into account time worked on a STAR program assignment, if any). The number of months and days are measured from the last day of the Notice Period. The amount of your biweekly payments will be your Covered Pay at the end of the Notice Period. You will receive these payments on a biweekly schedule unless you obtain a benefits-eligible position with another employer and request a lump-sum payment or obtain a new job within Wells Fargo during your expected leave and you request a lump-sum payment in accordance with the Plan.

Your Annual Benefits Base Rate is calculated quarterly, and earnings are annualized based on base salary, draw, and incentives, bonuses, or commissions paid in the last 12 months divided by the number of months with compensation greater than $0, up to a maximum of $100,000 per year (or $8,333 per month). The Annual Benefits Base 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 commute subsidies). However, if your position is assigned a VIC pay category and your annual base salary as shown on the Wells Fargo HRIS is greater than $100,000, then your covered pay for purposes of the Plan is your base salary. For purposes of the Plan, the Annual Benefits Base Rate may be expressed as an annual, monthly, or weekly amount.

If Wells Fargo’s Enterprise Compensation Department or Home Mortgage’s Compensation Department assigns your position a Mortgage Consultant Participant pay category (job class code 1), your covered pay is your Annual Benefits Base Rate up to $265,000 per year.
Salary continuation pay schedule

<table>
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<tr>
<th>Completed years of service</th>
<th>Salary Continuation Pay (8 weeks minimum)</th>
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<td>26+</td>
<td>52 weeks</td>
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The following applies to Participants who become employees of the Company or an Affiliate as a direct result of the transaction between: (i) General Electric Capital Corporation and Wells Fargo Bank, N.A. effective March 1, 2016, or (ii) General Electric Capital Corporation and First Union Rail Corporation effective January 1, 2016, and who experience a Qualifying Event during the one-year period following their first day of employment with the Company or an Affiliate: Salary Continuation Pay shall be the greater of: (a) the Salary Continuation Pay described above or (b) the severance pay that would have been available to such participant under the General Electric Capital Corporation Layoff Benefit Plan (one week of base salary or wages per completed year of service plus ¼ of a week’s salary for each additional three months of continuous service at the time of the Qualifying Event subject to a minimum of 10 weeks of base salary or wages) plus up to six months of health coverage at active rates or a cash payment equivalent thereto if the Participant’s Leave would not have exceeded six months under this Plan.

Agreement and general release

To qualify for salary continuation pay under the Plan, you must timely sign, return, and not effectively rescind the Agreement and Release (the “Agreement”) contained in your displacement packet. The Agreement is a document, signed by you and Wells Fargo, in which 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 have 45 days beginning with the first day of the Notice Period to consider the terms of the Agreement. However, if you are eligible for salary continuation pay as the result of a Qualified Medical Leave, you will have 21 days from the first day of the Notice Period to consider the terms of the Agreement. In each case, the period for review and return of the Agreement is set forth in your displacement packet. In addition, after you sign the Agreement, you will have a seven-day rescission period (15 days in Minnesota) during which you may take action to rescind the Agreement. If you sign the Agreement and do not rescind it during the rescission period, salary continuation pay will begin on the next payday following the Notice Period, unless you are a “specified employee” as defined by Internal Revenue Code Section 409A. For more information, see the “Specified employees” section on page 12-9.

If you choose not to sign the Agreement in a timely manner or if you rescind the Agreement, you will not receive salary continuation pay or be eligible for a Salary Continuation Leave, and unless you are returning from a Qualified Medical Leave, your employment will be terminated at the end of your Notice Period. Those returning from a Qualified Medical Leave, who either do not sign or effectively rescind the Agreement, will continue on their Job Search Leave for the balance of that designated leave period.

Notice Period

Unless your Qualifying Event is related to a Qualified Medical Leave, you typically will receive a 60-calendar-day “Notice Period” of a qualifying event unless applicable state law requires an extended notice period. Your business unit may designate that the Notice Period should be all working, all nonworking, or divided between working and nonworking.
There may be business circumstances in which participants in a business unit may be provided a shorter Notice Period, subject to the written approval of the Senior Human Resources Leader of the business unit and applicable state law. If your 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 the Notice Period. This unpaid leave of absence will terminate immediately:

- Upon Displacement Services’ timely receipt of your executed Agreement and upon satisfying the rescission period
- If you become ineligible to participate in the Plan
- If you exceed the 45-day Agreement review period without executing the Agreement

If your Qualifying Event is related to a Qualified Medical Leave, you will receive a 21-calendar-day Notice Period. This Notice Period will run concurrently with an unpaid Job Search Leave. You are not expected to be working, unless you accept a position with Wells Fargo.

**Specified employees**

If any payment under the Plan is considered to be “nonqualified deferred compensation” subject to the requirements of Internal Revenue Code Section 409A (“IRC 409A”) and you are a “specified employee” as defined and determined for purposes of IRC 409A, such payment will be delayed until the first day of the seventh calendar month following the last day of your Notice Period (the “waiting period”) to the extent that your salary continuation pay is not otherwise exempt from the application of the 20% excise tax under IRC 409A. The plan administrator will determine how to administer the waiting period. If you are a specified employee, you will be notified in your displacement packet and the application of the waiting period will be reflected in the Agreement and Release.

**Nature of benefits**

When benefits are due, they are paid from the general assets of your Wells Fargo employer, Wells Fargo & Company, 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 it may choose to do so at its discretion. Plan benefits may not be assigned. Participants do not make any contributions to the Plan.

**Right to coordinate other pay and benefits**

Salary Continuation pay provided under the Plan is not intended to be in addition to pay in lieu of notice, severance or change in control pay, or similar benefits under other severance programs, written employment agreements, or other applicable laws, such as the Worker Adjustment and Retraining Notification (WARN) Act. Should such other benefits be payable, benefits under this Plan will be reduced accordingly, or alternatively, benefits previously paid under this Plan will be treated as having been paid to satisfy such 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 12-12. In addition, your salary continuation pay will be integrated with the amount of any state-mandated disability benefits, any Workers’ Compensation benefits, and any Wells Fargo-sponsored disability benefits. Salary continuation pay and Salary Continuation Leave will be the primary benefit, thereby reducing the other disability benefits, Workers’ Compensation benefits, or both, so that you do not receive more than 100% of your predisability covered pay during the Salary Continuation Leave.

**Early termination of salary continuation pay**

Salary Continuation pay may stop sooner than described in the “Salary continuation pay schedule” on page 12-8 if any of the following applies to you.

- If you accept another position with Wells Fargo or an Affiliate, then your Salary Continuation Leave will end and you will not be paid any remaining salary continuation pay.
- If during your Salary Continuation Leave, you notify Wells Fargo’s Displacement Services in writing that you have begun a benefits-eligible job with a new employer, then your Salary Continuation Leave will end, you will be paid your remaining salary continuation pay in a lump-sum severance payment, and your employment with Wells Fargo will be terminated. If you subsequently accept a position with Wells Fargo or an Affiliate during the period that would have been covered by the Salary Continuation Leave, 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 Salary Continuation Leave would have ended if you had not taken the lump sum.
• You are required to report immediately to Wells Fargo’s Displacement Services any overpayment paid to you during the Notice Period or the Salary Continuation Leave. Pursuant to Wells Fargo’s Code of Ethics, 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.

• 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 Ethics and Business Conduct whether or not such conduct had been discovered while you were actively working for Wells Fargo, then your remaining Notice Period, Salary Continuation Leave, or both, will end and your employment with Wells Fargo will be terminated.

If you are called to duty and placed on an approved Military Leave either during your Notice Period or during your Salary Continuation Leave, your remaining Notice Period (if applicable) and Salary Continuation Leave are suspended until you are released to return to work following your completion of the approved Military Leave.

If you die, any remaining portion of your notice period or your Salary Continuation Leave will end and your remaining Notice Period pay (if applicable) and salary continuation 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 within 60 days following Wells Fargo’s receiving a copy of your death certificate as permitted by state law.

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, canceled, or recovered to ensure compliance with all such applicable laws, rules, regulations, and any guidance that may be issued thereunder.

Claims and appeals
Filing a claim
Normally, salary continuation pay will automatically be paid to all eligible participants who qualify under the Plan. However, if you have not received this benefit and you believe that you are entitled to it, or if you believe you are entitled to a larger benefit than described in your displacement packet, you may file a claim with the plan administrator.

For position eliminations and Qualified Events relating to return from a Qualified Medical Leave, you must file a claim within 90 days of any of the following:
• The date you learn the amount of salary continuation pay benefit available to you under the Plan
• The date you learn that there will be no salary continuation pay benefit available to you under the Plan

For substantial position changes, you must file a claim within 30 days of the date you are advised of the change to your current job.

Your claim must be in writing, must be signed by you or your duly authorized representative, and must briefly explain the basis for the claim (including any documentation in support of your claim). The claim should be delivered to the plan administrator as follows:

Plan Administrator
Wells Fargo & Company Salary Continuation Pay Plan
Attention: Enterprise Employee Relations
MAC D1130-110
301 South Tryon Street, 11th Floor
Charlotte, NC 28282-1915

The plan administrator has delegated the claims review responsibility and administration to Wells Fargo’s ER Policy department, which has the authority to further delegate to Wells Fargo’s Human Resources function as it deems appropriate. 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, not to exceed 90 days from the date your claim is received by the plan administrator, except that under special circumstances 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 why the extension is needed and when the
determination will be made. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, then the time from the date of the claim reviewer’s notice requesting further information and an extension until the claim reviewer receives the requested information does not count toward the time period that the claim reviewer is allowed to notify you of the claim determination.

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, and it will include a statement of your right to bring a 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 team members or any restricted information).

Claim denials and appeals
The plan administrator has delegated the responsibility to review appeals to the Salary Continuation Pay Plan Appeals Committee (the “Appeals Committee”). 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 that your claim was denied, you must submit your appeal to the Plan Administrator (in care of the Appeals Committee). For more information, see the “Plan administrator” section on page 12-12.

An appeal must be in writing and must include the following information:

- Your name
- Reference to the initial decision
- An explanation of why you are appealing the initial determination

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 all information submitted by you relating to your appeal, even though you may not have submitted such information with your original claim.

The Appeals Committee 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, except that under special circumstances the Appeals Committee 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 Committee 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 the 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 Committee sends you the final written decision.

When coverage ends
Your participation in the Plan ends when one of the following occurs:

- You voluntarily terminate your employment with Wells Fargo, you are involuntarily terminated for reasons other than a qualifying event, or you experience a disqualifying event.
- You no longer meet the 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 Salary Continuation Pay 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) 41-0449260 to Wells Fargo & Company. You should use this number and the PIN if you correspond with the government about the Plan.

Plan administrator

The plan administrator is Wells Fargo & Company. The plan administrator has full discretionary authority to administer and interpret the Plan and may, at any time, delegate to personnel of Wells Fargo, including ER Policy, and the Appeals Committee, such responsibilities as it considers appropriate to facilitate the day-to-day administration of the Plan. Communications to the plan administrator should be addressed to:

- Plan Administrator  
  Wells Fargo & Company Salary Continuation Pay Plan  
  Attention: Enterprise Employee Relations  
  MAC D1130-110  
  301 South Tryon Street, 11th Floor  
  Charlotte, NC 28282-1915

Because the provisions of the Plan are intended to serve only as a guideline for the payment of salary continuation benefits, no team member has a vested right to salary continuation 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.
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  
ARAGLegalCenter.com |
|---|---|
| Information about enrollment in the Legal Services Plan | Team Member Care (formerly known as the HR Service Center)  
1-877-HRWELLS (1-877-479-3557), option 2  
Team Member Care accepts relay service calls.  
TDD/TTY users may call 1-800-988-0161. |
| Information about premiums for the Legal Services Plan | Check your enrollment materials, or go to the rates and comparison chart on Teamworks. |
The information in this chapter — along with that in “Chapter 1: An Introduction to Your Benefits,” “Appendix B: Important Notifications and Disclosures,” and “Appendix D: Leaves of Absence and Your Benefits”— constitutes the Summary Plan Description (SPD) for the Legal Services Plan that provides certain benefits for legal services as described within this chapter.

The basics

Highlights

The Legal Services Plan provides the following benefits:

- **Access to ARAG’s Customer Care Specialists**, at 1-800-299-2345, who can assist you with finding an attorney and providing educational resources to assist you with your legal matter.

- **Legal representation and telephone advice from ARAG® Network Attorneys** for personal legal issues. Network Attorney fees for covered benefits are 100% paid in full unless otherwise stated. You may also call a Telephone Network Attorney for general legal advice and consultation as often as necessary for covered services, at no additional cost to you.

  **Note:** Attorneys who are participants in ARAG’s Attorney Network are referred to as “Network Attorneys” throughout this SPD.

- **Online legal tools and educational resources.** The Legal Services Plan provides DIY Docs®, a Law Guide, Attorney Finder, identity theft resources, legal assessment tool, and an education center.

- **The option to see an attorney outside of the ARAG Network and receive reimbursement for a portion of the fees** for covered services according to a schedule (refer to the “Covered services” section starting on page 13-6). You may choose to see any attorney not in the network (Non-Network Attorney) and file a claim for reimbursement of covered services. You can recommend an attorney for inclusion in the Network by simply calling ARAG. ARAG has discretion as to which attorneys are included in the Attorney Network.

**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; GuideOne Mutual Insurance Company of West Des Moines, Iowa; or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. ARAG has the responsibility in its sole discretion to administer and interpret the terms of the Legal Services Plan and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the Legal Services Plan.

**Who’s eligible**

Regular and part-time Wells Fargo team members are eligible to enroll in the Legal Services Plan. Dependent coverage is also available. Flexible team members and their dependents are not eligible. For more information about eligibility for legal services coverage, please see “Chapter 1: An Introduction to Your Benefits.” You may not be covered under the Legal Services Plan as both a team member and as a spouse, domestic partner, or dependent child at the same time. Also, a dependent can only be covered under one team member. In the event of double coverage while you’re a benefits-eligible team member, only your claim as a team member will be honored.

**How to enroll**

**Initial enrollment**

You may enroll in the Legal Services Plan during your designated enrollment period if you are one of the following:

- A newly hired benefits-eligible team member
- A team member who has had an employment classification change to a benefits-eligible position
- A rehired benefits-eligible team member

To enroll, access the benefits enrollment site on Teamworks at work or at home during the designated enrollment period. Refer to the “When to enroll — when benefits take effect” section in “Chapter 1: An Introduction to Your Benefits” to determine your designated enrollment period.

If you enroll during your designated enrollment period, your coverage is effective the first of the month following one full calendar month of service in a benefits-eligible position.
Late enrollment

If you do not enroll during your designated enrollment period, you must generally wait until the next Annual Benefits Enrollment period, unless you experience an event that would allow you to enroll outside of the initial designated enrollment period. See the “Qualified Events” section in “Chapter 1: An Introduction to Your Benefits” for more information.

If you enroll during Annual Benefits Enrollment, your coverage is effective the following January 1.

If you enroll due to a Qualified Event, coverage is effective the first of the month following the date of the event or the first of the month following the date you contact Team Member Care (formerly known as the HR Service Center), whichever is later.

Changing coverage

Once you enroll, you cannot cancel or modify your benefit election or coverage level during the plan year unless you have an applicable Qualified Event. See the “Qualified Events” section in “Chapter 1: An Introduction to Your Benefits” for more information.

Paying for your benefits

Team members pay the full cost for coverage. Each pay period, you pay premiums for your Legal Services Plan coverage through after-tax payroll deductions. Wells Fargo does not contribute toward payment of the premium.

The amount you pay for coverage depends on the coverage level you elect — You only or You + family.

Benefits when you are not working

You must continue paying the premiums to maintain coverage while you are on an approved leave of absence. If coverage was canceled due to nonpayment of premiums, you must generally wait until the next Annual Benefits Enrollment period to reenroll. For more information about your benefits when you are not working, please see “Appendix D: Leaves of Absence and Your Benefits.”

How the Legal Services Plan works

After enrollment, you will receive a member kit, which includes a welcome letter, two member cards, and a member guide. You must be enrolled in the Legal Services Plan on the date you receive legal services to be eligible for applicable benefits. There are three ways to use the Legal Services Plan:

1. Online tools and resources
2. Legal advice and representation from Network Attorneys
3. Legal advice and representation from Non-Network Attorneys

When you are in need of an attorney, have questions about your legal plan, or need help finding resources about a legal topic, call one of ARAG’s Customer Care Specialists at 1-800-299-2345. ARAG suggests that you always call and speak with a Customer Care Specialist before hiring an attorney so that they can confirm that your case is a covered service.

An ARAG Customer Care Specialist may assist in providing the following information:

- **Personal Network Attorney Search**: You will receive a list of Network Attorneys in your area who serve your legal matter.
- **CaseAssist® Confirmation**: Specialists will make sure your personal claim and coverage information is sent directly to you and the Network Attorney of your choice, so he or she can begin working on your case.
- **Educational Information**: You will have a wealth of resources, including tips on how to work with an attorney and an appointment preparation checklist.

Online tools and resources

Start using your online legal resources right away with the ARAG Legal Center. Sign on by completing the following steps:

1. Go to ARAGLegalCenter.com, access code: 16862wfc.
2. Click on the Member Login button.
3. The first time you log in, you will create a personal user name and password.

While creating your member login, you will be asked if you want to receive the LawExpresso® Newsletter during the registration process. Please note that by subscribing to the newsletter, you will receive a monthly e-newsletter that provides you with legal tips.
As a participant in the Legal Services Plan, you have access to the following online tools and resources through the ARAG Legal Center.

- **Education Center** — Access to Guidebooks and Videos, a Law Guide, the LawExpresso® e-newsletter, Personal Information Organizer, and other educational resources that offer tips and tools for dealing with everyday legal issues.

- **Find an Attorney** - Search for a Network Attorney by name, city, county, or zip code and distance. ARAG suggests that you always call ARAG Legal Center and speak with an ARAG Customer Care Specialist before hiring an attorney so that ARAG can confirm that your case is a covered service.
  
  You will also find tips on how to prepare for a visit, how to work with an attorney, and information about the network.

- **Online Resources** — Access to plan documents, including the Non-Network Attorney Claim Form and the Certificate of Insurance coverage, DIY Docs® where you can browse templates and use an interactive online tool that allows you to efficiently create legally valid documents such as Wills or Power of Attorney at your own pace, tips on ID theft, member stories, and assessment tools.

Note: These online tools and resources are provided to you by ARAG. Wells Fargo is not involved in the development, creation, maintenance, or updating of these online tools and resources. Additionally, Wells Fargo does not make any representations or warranties with respect to these online tools and resources provided by ARAG under the Legal Services Plan. Further, providing the use of these tools and resources under the Legal Services Plan is for general information purposes only and does not constitute the providing of legal advice by Wells Fargo & Company or any of its subsidiaries or affiliates. You should consult with your own attorney regarding your own individual situation.

**Network advice from Network Attorneys**

Network Attorneys must meet specific requirements to become part of ARAG’s Attorney Network, but are independent contractors responsible for the delivery of their own services. Wells Fargo does not certify the quality of the attorneys in the network.

Network Attorney fees are covered in full for all covered services unless otherwise stated. Refer to the “Covered services” section starting on page 13-6 for more information.

**Network access**

As a participant in the Legal Services Plan, you are guaranteed access to a Network Attorney within 30 miles of your home. If you find there aren’t any Network Attorneys available in your local area, ARAG will locate an attorney from whom you may receive in-network benefits. To receive assistance, contact the ARAG Customer Care Center and tell the specialist your situation. (Access to attorneys who offer reduced fee services is not included in this guarantee.)

**Telephone network**

Many legal needs can be handled conveniently and quickly by a Network Attorney over the telephone. Telephone Network Attorneys may provide the following services over the phone:

- General legal advice
- Assistance with the preparation of the following documents:
  - Special powers of attorney and revocations
  - Child care authorizations
  - Challenge to denial of credit
  - Bad check notice
  - Promissory notes and affidavits related to your personal property
- Bills of sale related to your personal property
- Review of documents up to four pages in length (does not include documents related to trusts or real estate property transfers)
- Follow-up correspondence and phone calls to third parties as necessary
- Standard will preparation, including:
  - Testamentary trusts for minor children
  - Specific bequests
  - Durable powers of attorney
  - Health care powers of attorney and revocations
  - Living wills and advance health care directives

- Immigration legal advice and consultation on:
  - Immigration processes and guidelines
  - Filing and processing of applications and petitions
  - Laws and regulations governing various types of immigration benefits, including asylum, adjustment of status, business visas, and employment authorizations
  - Deportation and removal proceedings
Advice provided by a Network Attorney applies only to the law as it relates to situations personally involving you in the United States. Also note that telephone legal advice and consultation do not provide ongoing advice about complex legal matters or legal matters for which you have already retained an attorney.

Network Attorneys can be reached by phone Monday through Friday from 9:00 a.m. to 5:00 p.m. local time. You can choose any of the attorneys in the ARAG Network and you may call as often as necessary, at no additional cost to you.

To speak to a Network Attorney over the phone, contact ARAG directly at 1-800-299-2345 or at the number on your identification card. When you contact ARAG’s Customer Care Center, you will need to enter your unique member identification number shown on your identification card.

**Local network**

You can meet with a local Network Attorney over the phone or in-office. Appointments with a Network Attorney can be made by calling an attorney in ARAG’s Network and identifying yourself as a member of the Wells Fargo Legal Services Plan through ARAG. You can choose any of the attorneys in the ARAG Network. As a member, you will receive a membership card that contains a personal member identification number. Please present this card or your personal ID number when working with a Network Attorney.

**Legal advice from Non-Network Attorneys**

You also have the option to see an attorney outside of ARAG’s Network. However, coverage will only be provided for covered services in the amount described in the “Covered services” table starting on page 13-7. After your office visit, simply file a claim form along with your attorney’s invoice within 120 days of the date you incur the legal fee (refer to the “Claims for benefits” section starting on page 13-14). You will receive direct reimbursement, up to the maximum allowed by the Legal Services Plan.

**Covered services**

The Legal Services Plan covers services differently depending on whether or not you use an attorney in ARAG’s Network as described in the “Covered services” table starting on page 13-7. When you use a Network Attorney, the attorney fees for most covered legal services are paid in full. Limits apply to benefits if you use a Non-Network Attorney.
## Covered services

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Attorney</th>
<th>Non-Network Attorney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone legal advice and consultation</td>
<td>Paid in full</td>
<td>No coverage</td>
</tr>
<tr>
<td>Identity theft services</td>
<td>Unlimited access to an identity theft case manager is paid in full</td>
<td>No coverage</td>
</tr>
<tr>
<td>Reduced fee services</td>
<td>At least 25% off Network Attorneys’ standard hourly rate for services that are: (i) not covered, but (ii) not specifically excluded from coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Immigration</td>
<td>Network Attorneys provide a reduced rate of at least 25% off their normal rates for any document review, preparation, or representation-based immigration services</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

### In-office or courtroom services

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Attorney</th>
<th>Non-Network Attorney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenuptial agreements (between you and your prospective spouse)</td>
<td>Paid in full</td>
<td>$300^a</td>
</tr>
<tr>
<td>Dissolution of marriage(^1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Uncontested</td>
<td>Paid in full</td>
<td>$480^b</td>
</tr>
<tr>
<td>• Contested</td>
<td>Paid in full up to 20 hours per event (Additional hours over 20 are not covered by the Legal Services Plan, but are billed to you by the Network Attorney at a reduced rate)</td>
<td>$1,080^b</td>
</tr>
<tr>
<td>Name change</td>
<td>Paid in full</td>
<td>$240^b</td>
</tr>
<tr>
<td>Juvenile court</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$480^b</td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200^c</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000^d</td>
</tr>
<tr>
<td>Parental responsibilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$480^b</td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200^c</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000^d</td>
</tr>
</tbody>
</table>

1. Coverage for services provided for the contested dissolution of marriage is capped at 20 hours. Coverage is limited to the named insured.
2. Coverage is limited to $60 per hour, and total coverage is capped at the stated amount per event. You must pay any additional fees charged by the Attorney that exceed the stated amount.
3. Court representation at trial indemnity benefits of $1,200 for up to three days of trial time are included in this amount ($200 per half day for trial time). You must pay any additional fees charged by the Non-Network Attorney for trial work that exceeds $1,200 per event.
4. Court representation at trial indemnity benefits of $100,000 starting on day four until completion are included in this amount ($400 per half day for trial time). You must pay any additional fees charged by the Non-Network Attorney for trial work that exceeds $100,000 per event.
<table>
<thead>
<tr>
<th>Service</th>
<th>Network Attorney</th>
<th>Non-Network Attorney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court adoption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Uncontested</td>
<td>Paid in full</td>
<td>$300*</td>
</tr>
<tr>
<td>• Contested</td>
<td>Paid in full</td>
<td>$300*</td>
</tr>
<tr>
<td>– Advice, negotiation, and office work</td>
<td>Paid in full</td>
<td>$1,200*</td>
</tr>
<tr>
<td>prior to a lawsuit being filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200*</td>
</tr>
<tr>
<td>– Trial starting on day four (4) until</td>
<td>Paid in full</td>
<td>$100,000*</td>
</tr>
<tr>
<td>completion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In international adoptions, where a foreign</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attorney is necessary, you are eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to receive indemnity reimbursement in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>addition to the benefits available in the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guardianship or conservatorship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Uncontested</td>
<td>Paid in full</td>
<td>$300*</td>
</tr>
<tr>
<td>• Contested</td>
<td>Paid in full</td>
<td>$540*</td>
</tr>
<tr>
<td>– Advice, negotiation, and office work</td>
<td>Paid in full</td>
<td>$1,200*</td>
</tr>
<tr>
<td>prior to a lawsuit being filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200*</td>
</tr>
<tr>
<td>– Trial starting on day four (4) until</td>
<td>Paid in full</td>
<td>$100,000*</td>
</tr>
<tr>
<td>completion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child support enforcement</td>
<td>Paid in full</td>
<td>$360*</td>
</tr>
<tr>
<td>Post-decree enforcement</td>
<td>Paid in full</td>
<td>$360*</td>
</tr>
<tr>
<td>Post-decree defense</td>
<td>Paid in full</td>
<td>$360*</td>
</tr>
<tr>
<td>Protection from domestic violence (</td>
<td>Paid in full</td>
<td>$300*</td>
</tr>
<tr>
<td>before or without trial representation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wills and durable power of attorney</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Standard will</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Individual</td>
<td>Paid in full</td>
<td>$150</td>
</tr>
<tr>
<td>– Spousal or domestic partner document</td>
<td>Paid in full</td>
<td>$150</td>
</tr>
<tr>
<td>– Codicil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>° Single document</td>
<td>Paid in full</td>
<td>$40</td>
</tr>
<tr>
<td>° Spousal or domestic partner document</td>
<td>Paid in full</td>
<td>$60</td>
</tr>
<tr>
<td>• Living will or health care directive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Single document</td>
<td>Paid in full</td>
<td>$35</td>
</tr>
<tr>
<td>– Spousal or domestic partner document</td>
<td>Paid in full</td>
<td>$50</td>
</tr>
<tr>
<td>• Complex wills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Individual</td>
<td>Paid in full</td>
<td>$150</td>
</tr>
<tr>
<td>– Spousal or domestic partner document</td>
<td>Paid in full</td>
<td>$150</td>
</tr>
<tr>
<td>• Durable or financial power of attorney</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Single document</td>
<td>Paid in full</td>
<td>$35</td>
</tr>
<tr>
<td>– Spousal or domestic partner document</td>
<td>Paid in full</td>
<td>$50</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Service</th>
<th>Network Attorney</th>
<th>Non-Network Attorney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revocable trusts</td>
<td>Paid in full</td>
<td>$180²</td>
</tr>
<tr>
<td>Irrevocable trusts</td>
<td>Paid in full</td>
<td>$180²</td>
</tr>
<tr>
<td>Consumer protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$600²</td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200³</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000⁴</td>
</tr>
<tr>
<td>Defense of debt collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$600²</td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200³</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000⁴</td>
</tr>
<tr>
<td>Defense of garnishment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$600²</td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200³</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000⁴</td>
</tr>
<tr>
<td>Foreclosure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$600²</td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200³</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000⁴</td>
</tr>
<tr>
<td>Bankruptcy (up to and including)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Filing of a Chapter 7 bankruptcy final report</td>
<td>Paid in full</td>
<td>$880</td>
</tr>
<tr>
<td>• Confirmation of a Chapter 13 bankruptcy, including post-confirmation amendments</td>
<td>Paid in full</td>
<td>$1,200²</td>
</tr>
<tr>
<td>Personal property protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$600²</td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200³</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000⁴</td>
</tr>
<tr>
<td>Neighbor disputes (primary and secondary residence)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$600²</td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200³</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000⁴</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Service</th>
<th>Network Attorney</th>
<th>Non-Network Attorney</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Real estate disputes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(primary and secondary residence)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior</td>
<td>Paid in full</td>
<td>$600&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>to a lawsuit being filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>completion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tenant matters</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior</td>
<td>Paid in full</td>
<td>$240&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>to a lawsuit being filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>completion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estate administration and closings</strong></td>
<td>Paid in full up to 9 hours per event</td>
<td>$540&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>(Additional hours over 9 are not covered by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the Legal Services Plan, but are billed to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>you by the Network Attorney at a reduced rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Building codes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior</td>
<td>Paid in full</td>
<td>$360&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>to a lawsuit being filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>completion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Easements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior</td>
<td>Paid in full</td>
<td>$360&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>to a lawsuit being filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>completion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Zoning and variances</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior</td>
<td>Paid in full</td>
<td>$360&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>to a lawsuit being filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>completion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social Security, Medicare, or veterans</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>issues</td>
<td>Paid in full</td>
<td>$480&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>to a lawsuit being filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>completion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>School administrative hearings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior</td>
<td>Paid in full</td>
<td>$480&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>to a lawsuit being filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>completion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Service</th>
<th>Network Attorney</th>
<th>Non-Network Attorney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase or sale of real estate</td>
<td>Paid in full</td>
<td>$360&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sale of primary and secondary residence</td>
<td>Paid in full</td>
<td>$360&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Purchase of primary and secondary residence</td>
<td>Paid in full</td>
<td>$360&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Refinancing (primary and secondary residence)</td>
<td>Paid in full</td>
<td>$160&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Advice and review of relevant documents regarding refinancing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document preparation and review</td>
<td>Paid in full</td>
<td>$50 per document</td>
</tr>
<tr>
<td>Deeds</td>
<td>Paid in full</td>
<td>$50 per document</td>
</tr>
<tr>
<td>Mortgages</td>
<td>Paid in full</td>
<td>$50 per document</td>
</tr>
<tr>
<td>Promissory notes</td>
<td>Paid in full</td>
<td>$50 per document</td>
</tr>
<tr>
<td>Affidavits</td>
<td>Paid in full</td>
<td>$50 per document</td>
</tr>
<tr>
<td>Lease contracts</td>
<td>Paid in full</td>
<td>$50 per document</td>
</tr>
<tr>
<td>Demand letters</td>
<td>Paid in full</td>
<td>$50 per document</td>
</tr>
<tr>
<td>Installment contracts</td>
<td>Paid in full</td>
<td>$50 per document</td>
</tr>
<tr>
<td>Property tax assessment</td>
<td>Paid in full</td>
<td>$380&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$600&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Civil damage claim defense (excludes motorized vehicles)</td>
<td>Paid in full</td>
<td>$320&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$600&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Small claims court</td>
<td>Paid in full</td>
<td>$400&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Advice and counseling to bring a claim in small claims court (or similar court of limited civil jurisdiction)</td>
<td>Paid in full</td>
<td>$480&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Defend an action in small claims court (including representation in court where allowed by law)</td>
<td>Paid in full</td>
<td>$480&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Criminal misdemeanor protection</td>
<td>Paid in full</td>
<td>$480&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td>$480&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>2</sup> Coverage is limited to $60 per hour, and total coverage is capped at the stated amount per event. You must pay any additional fees charged by the Attorney that exceed the stated amount.

<sup>3</sup> Court representation at trial indemnity benefits of $1,200 for up to three days of trial time are included in this amount ($200 per half day for trial time). You must pay any additional fees charged by the Non-Network Attorney for trial work that exceeds $1,200 per event.

<sup>4</sup> Court representation at trial indemnity benefits of $100,000 starting on day four until completion are included in this amount ($400 per half day for trial time). You must pay any additional fees charged by the Non-Network Attorney for trial work that exceeds $100,000 per event.
<table>
<thead>
<tr>
<th>Service</th>
<th>Network Attorney</th>
<th>Non-Network Attorney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driving privilege protection (excludes DUI offenses)</td>
<td></td>
<td>$360^2</td>
</tr>
<tr>
<td>• Traffic charge defense (when driving privilege is in jeopardy)</td>
<td></td>
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</tr>
<tr>
<td>– Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td></td>
</tr>
<tr>
<td>– Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200^3</td>
</tr>
<tr>
<td>– Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000^4</td>
</tr>
<tr>
<td>• Driving privilege restoration (excludes DUI offenses)</td>
<td>Paid in full</td>
<td>$240^2</td>
</tr>
<tr>
<td>Minor traffic offense (excludes DUI offenses)</td>
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<td>$180^5</td>
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<td>IRS audit protection</td>
<td></td>
<td>$480^2</td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200^3</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000^4</td>
</tr>
<tr>
<td>IRS collection defense</td>
<td></td>
<td>$480^2</td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200^3</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000^4</td>
</tr>
<tr>
<td>State tax audit protection</td>
<td></td>
<td>$480^2</td>
</tr>
<tr>
<td>• Advice, negotiation, and office work prior to a lawsuit being filed</td>
<td>Paid in full</td>
<td></td>
</tr>
<tr>
<td>• Trial for three (3) days or less</td>
<td>Paid in full</td>
<td>$1,200^3</td>
</tr>
<tr>
<td>• Trial starting on day four (4) until completion</td>
<td>Paid in full</td>
<td>$100,000^4</td>
</tr>
</tbody>
</table>

2. Coverage is limited to $60 per hour, and total coverage is capped at the stated amount per event. You must pay any additional fees charged by the Attorney that exceed the stated amount.

3. Court representation at trial indemnity benefits of $1,200 for up to three days of trial time are included in this amount ($200 per half day for trial time). You must pay any additional fees charged by the Non-Network Attorney for trial work that exceeds $1,200 per event.

4. Court representation at trial indemnity benefits of $100,000 starting on day four until completion are included in this amount ($400 per half day for trial time). You must pay any additional fees charged by the Non-Network Attorney for trial work that exceeds $100,000 per event.

Limitations and exclusions apply. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa; GuideOne® Mutual Insurance Company of West Des Moines, Iowa; or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits, or exclusions, call 1-800-888-4184.
Plan exclusions and limitations

The exclusions listed below do not constitute a complete listing of excluded or limited services. If you have a question about coverage for a specified service, please contact ARAG directly.

The Legal Services Plan does not cover the following:

- An event that occurs before the effective date of coverage, including a written notice of a legal dispute that is sent or filed by you or received by you before your effective date of coverage under this plan; a ticket or citation is issued before your effective date of coverage under this plan; or an attorney is hired before your 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, or other service provider to such benefit plan
- Legal services arising out of a business interest, investment interests, employment matters, your role as an officer or director of an organization, and patents or copyrights
- Legal services for class actions, punitive damages, or malpractice
- Legal services in post judgments or for appeals
- Legal services for court action brought in small claims court or equivalent court in your state
- Legal services deemed by ARAG to be frivolous or lacking merit
- Legal services for actions where you are the plaintiff and the amount ARAG pays or would pay for your legal services exceeds the amount in dispute
- Legal services where ARAG has reasonable belief that you are not actively and reasonably pursuing a resolution in your case
- Charges above the stated limits in the “Covered services” section on page 13-6
- Charges for services not listed in the “Covered services” section on page 13-6

When coverage ends

Coverage under the Legal Services Plan ends on the last day of the month in which:

- Your last day of employment takes place.
- You no longer meet the eligibility requirements.
- The Legal Services Plan is discontinued or terminated.*
- You voluntarily make a permitted election to drop coverage. Refer to the “Changing coverage” section 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.)
- The premiums for your Legal Services Plan coverage are not paid as due.
- You die.

Coverage for your 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 your covered dependents may have the option of converting their policy to an individual policy.

* For information on Wells Fargo’s ability to amend, modify, or terminate the Legal Services Plan, see the “Future of the plans” section in “Appendix B: Important Notifications and Disclosures.”

Continuing your coverage directly with the carrier

If you leave Wells Fargo’s employment or become otherwise ineligible, you have the option to convert your coverage to an individual policy. ARAG will send enrolled team members a personalized communication about continuation of coverage within 31 days of the date your coverage ends (end of the month of your last day of employment). You may also contact ARAG directly at 1-800-299-2345 and request a Conversion Application Form. Return the completed form and any applicable payment to ARAG within 90 days from the date your coverage ends (end of the month of your last day of employment) to enroll directly with ARAG. For more information concerning your eligibility for conversion coverage, contact ARAG directly at 1-800-299-2345.
Claims and appeals

Claims for benefits

ARAG administers all claims for benefits under the Legal Services Plan. To file a claim for Non-Network Attorney services, obtain a claim form by logging in as a member to the ARAG® Legal Center™ website at ARAGLegalCenter.com or by contacting ARAG Customer Care at 1-800-299-2345. Submit the claim form with an itemized attorney invoice within 120 days of completion of the legal services. Claims for benefits should be sent to ARAG at the following address:

ARAG  
Attention: Claims  
400 Locust Street  
Suite 480  
Des Moines, IA 50309-2337

ARAG also is the claims fiduciary responsible for benefit determinations. ARAG has the responsibility in its sole discretion to administer and interpret the terms of the Legal Services Plan, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the Legal Services Plan. Its decisions on these matters are conclusive. Any interpretation or determination made pursuant to this discretionary authority shall be subject to limited judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (that is, arbitrary and capricious).

If a benefit claim, or any part of it, is denied, you or your beneficiary must be notified within 90 days after ARAG receives the claim. There may be special circumstances in which it may take more than 90 days to get a decision on a claim. If this happens, the person making the claim will be notified in writing of the reasons for the delay and the date by which a final decision can be expected. The person filing the claim will be informed about the delay before the initial 90 days have passed.

If ARAG denies all or part of your claim, you or your beneficiary will be notified in writing. This notice will include:

- Specific reasons why the claim was denied
- Specific reference to the provisions of the group policy or other relevant records or papers, and information regarding where you may see them
- Descriptions of any additional material or information that must be supplied in order to satisfy the claim requirements, along with an explanation of why such material or information is necessary
- Instructions on how to appeal for reconsideration of ARAG’s decision
- A statement of the claimant’s right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination
- A statement that you may request copies of the documents relevant to the denial

Appealing a denied claim

If you disagree with ARAG’s claim decision, you have the right to file an appeal. Your appeal must be filed in writing to ARAG within 60 days of notification of the original claim denial. When filing your appeal, you should also submit to ARAG, in writing, the claim form and any information or comments pertinent to the review that support why your claim should be paid. Submit your appeal to:

ARAG  
Attention: Claims  
400 Locust Street  
Suite 480  
Des Moines, IA 50309-2337

The review process does not permit you, your beneficiary, or your authorized representative to appear in person before, or meet with, ARAG. ARAG must review the claim appeal as expeditiously as possible and also must give due consideration to any information or comments submitted in writing by, or on behalf of, the claimant. ARAG will make an appeal determination within 60 days if reasonably possible.

If there are special circumstances and an appeal determination cannot be made within 60 days, ARAG will be allowed additional time, but it must reach a decision within 120 days after receipt of the appeal. After ARAG has completed the review of the claim appeal, a written appeal determination will be issued to you or your authorized representative. It will include the specific references to the pertinent provisions of the Legal Services Plan on which the decision is based and a statement indicating your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. In addition, after ARAG has completed its final review of the claim on appeal, you will have the right to file suit in federal court in accordance with ERISA Section 502(a).
Legal action

No legal action can be made to recover expenses before you have exhausted the appeal procedures outlined in the “Claims and appeals” section starting on page 13-14. 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
400 Locust Street
Suite 480
Des Moines, IA 50309-2337
Appendix A
Claims and Appeals

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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:
  - HRA-Based Medical Plan
  - HSA-Based Medical Plan – Gold
  - HSA-Based Medical Plan – Silver
- Anthem Blue Cross Blue Shield administered:
  - HRA-Based Medical Plan
  - HSA-Based Medical Plan – Gold
  - HSA-Based Medical Plan – Silver
  - Indemnity Medical Plan
- HealthPartners administered:
  - HRA-Based Medical Plan
  - HSA-Based Medical Plan – Gold
  - HSA-Based Medical Plan – Silver
  - Indemnity Medical Plan
- CVS Caremark administered prescription drug benefit:
  - HRA-Based Medical Plan
  - HSA-Based Medical Plan – Gold
  - HSA-Based Medical Plan – Silver
  - Indemnity Medical Plan – Anthem
- Delta Dental Standard and Enhanced
- Vision Service Plan (VSP)

**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 listed above are also found in the individual medical, dental, vision, and flexible spending accounts chapters of this *Benefits Book.*

Important information about health and wellness activities and dollars:

- If you are enrolled in the HRA-Based Medical Plan, HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver, or an HDHP Kaiser medical plan option and have completed a health and wellness activity but have not had the applicable earned health and wellness dollars deposited into your health reimbursement account or health savings account, as applicable, within 30 days of the date you completed the activity, see the “Health and wellness dollar disputes” section in “Chapter 2: Medical Plans” for information about filing a formal inquiry 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 your claims administrator. Your inquiry to Optum will function as your claim with respect to these health and wellness dollars.

- While the health and wellness activities under the HRA-Based Medical Plan, HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver, or the HDHP Kaiser medical plan options are not outcome-based (that is, they do not require you to achieve particular health outcomes), there may be situations where you are unable to complete a biometric screening, or other qualified activity, to earn health and wellness dollars. Please see the “Requests for accommodations” section in “Chapter 2: Medical Plans” for more information on how to request an accommodation with Optum; 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, Summary Plan Description, or similar documentation you receive directly from Kaiser for applicable claims appeals and procedures.

If you are enrolled in the fully insured UnitedHealthcare Global — Expatriate Insurance plan, refer to the separate Certificate of Coverage, Summary Plan Description, or similar documentation that you received upon enrolling in the plan for applicable claims appeals and procedures.

For information about the claims and appeals procedures for benefit options not addressed above, refer to the applicable chapter within this *Benefits Book.*
The claims and appeals procedures stated in this appendix are intended to comply with applicable regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions, and appeals of adverse benefit determinations. You’ll need to follow these procedures for all claims for benefits arising from each benefit option listed above.

Your claim will be processed for payment according to the applicable plan provisions, the guidelines used by the applicable claims administrator, and the claim coding submitted by the provider. The applicable claims administrator is the named claims and appeals fiduciary and has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the Summary Plan Description (SPD) or other instruments governing the applicable plan or benefit option.

An issue or dispute solely regarding your eligibility for coverage or participation in one or more of the plans or benefit options is not considered a claim for benefits and is not governed by the claims and appeals procedures described in this appendix. For more information, please call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2.

**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 applicable law 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.

**Claimant**

A claimant is a participant in the applicable benefit option under the Health Plan or the Health Care Flexible Spending Account Plan, or his or her 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 Health Plan’s benefit option specifically requires approval or authorization from the applicable claims administrator before obtaining services to receive benefits. 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 nonurgent 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 “nonnetwork”) 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 his or her benefits to another party, the plan will still pay only your provider. However, any benefits under the Delta Dental coverage options for services received from an out-of-network provider will be paid directly to you, regardless of any assignment of benefits on file.

You are responsible for meeting any annual deductible and for paying established copayments (if applicable) and coinsurance to the out-of-network provider. You are also responsible for payment in full of any charges incurred that are not covered by the plan, including amounts the out-of-network provider has billed in excess of the allowed amount.

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 team member
- 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

<table>
<thead>
<tr>
<th>Benefit option</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare administered:</td>
<td>UnitedHealthcare</td>
</tr>
<tr>
<td>• HRA-Based Medical Plan</td>
<td>1-800-842-9722 For urgent care claims, specifically state that the claim is an urgent care claim.</td>
</tr>
<tr>
<td>• HSA-Based Medical Plan – Gold</td>
<td>UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130 For prescription drug claims, refer to the information in the row titled “CVS Caremark administered prescription drug benefit.” below.</td>
</tr>
<tr>
<td>• HSA-Based Medical Plan – Silver</td>
<td></td>
</tr>
<tr>
<td>• Indemnity Medical Plan</td>
<td></td>
</tr>
<tr>
<td><strong>Anthem Blue Cross Blue Shield administered:</strong></td>
<td>Anthem Blue Cross Blue Shield</td>
</tr>
<tr>
<td>• HRA-Based Medical Plan</td>
<td>1-866-418-7749 For urgent care claims, specifically state that the claim is an urgent care claim.</td>
</tr>
<tr>
<td>• HSA-Based Medical Plan – Gold</td>
<td>Anthem Blue Cross Blue Shield 11 Corporate Woods Mail Drop R5L Albany, NY 12211 For prescription drug claims, refer to the information in the row titled “CVS Caremark administered prescription drug benefit.” below.</td>
</tr>
<tr>
<td>• HSA-Based Medical Plan – Silver</td>
<td></td>
</tr>
<tr>
<td>• Indemnity Medical Plan</td>
<td></td>
</tr>
<tr>
<td><strong>HealthPartners administered:</strong></td>
<td>HealthPartners 952-883-5800 or 1-800-942-4872 For urgent care claims, specifically state that the claim is an urgent care claim.</td>
</tr>
<tr>
<td>• HRA-Based Medical Plan</td>
<td>For prescription drug claims, refer to the information in the row titled “CVS Caremark administered prescription drug benefit.” below.</td>
</tr>
<tr>
<td>• HSA-Based Medical Plan – Gold</td>
<td></td>
</tr>
<tr>
<td>• HSA-Based Medical Plan – Silver</td>
<td></td>
</tr>
<tr>
<td>• Indemnity Medical Plan</td>
<td></td>
</tr>
<tr>
<td><strong>CVS Caremark administered prescription drug benefit:</strong></td>
<td>CVS Caremark 1-800-626-3046 • By fax: 1-888-836-0730 For urgent care claims, specifically state that the claim is an urgent care claim.</td>
</tr>
<tr>
<td>• HRA-Based Medical Plan</td>
<td>For prescription drug claims, refer to the information in the row titled “CVS Caremark administered prescription drug benefit.” below.</td>
</tr>
<tr>
<td>• HSA-Based Medical Plan – Gold</td>
<td></td>
</tr>
<tr>
<td>• HSA-Based Medical Plan – Silver</td>
<td></td>
</tr>
<tr>
<td>• Indemnity Medical Plan — Anthem</td>
<td></td>
</tr>
<tr>
<td><strong>Fully insured medical plans (including Kaiser medical plan options and UnitedHealthcare Global — Expatriate Insurance)</strong></td>
<td>For information, refer to your Evidence of Coverage, Certificate of Coverage, Summary Plan Description, or similar documentation you received for your medical plan.</td>
</tr>
<tr>
<td><strong>Delta Dental:</strong></td>
<td>Not applicable. For pretreatment estimates, see “Chapter 3: Dental Plan.”</td>
</tr>
<tr>
<td>• Standard</td>
<td></td>
</tr>
<tr>
<td>• Enhanced</td>
<td></td>
</tr>
<tr>
<td><strong>Vision Service Plan (VSP)</strong></td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Flexible spending accounts:</strong></td>
<td>Not applicable.</td>
</tr>
<tr>
<td>• Full-Purpose Health Care FSA</td>
<td></td>
</tr>
<tr>
<td>• Limited Dental/Vision FSA</td>
<td></td>
</tr>
</tbody>
</table>

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.”
Filing a post-service claim

Post-service claims must contain all the information described in this section (except for Full-Purpose Health Care FSA or Limited Dental/Vision FSA claims, which are addressed in “Chapter 5: Health Care Flexible Spending Account Plan (Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)”). If you don’t submit the necessary information to the applicable claims administrator within the time frame for claims submissions for the applicable benefit option, benefits for the services received will be denied. Refer to the “Contacts for post-service claims” table starting on page A-8 for important information about claim submission deadlines and the address to which claims should be submitted.

- In general, if you receive services from a network provider, the network provider will file a post-service claim on your behalf. However, you should always check with your network provider to make sure the claim has been filed within the proper time frame to avoid denial of benefits for missing the claim filing deadline.

- If you receive services from an out-of-network provider, you’re responsible for ensuring that the claim is filed correctly and on time, even if the out-of-network provider offers to file the claim on your behalf. You must complete the appropriate claim form and provide an itemized original bill* from your out-of-network provider that includes all of the following:
  - Patient’s name, date of birth, and patient diagnosis codes
  - Dates of service
  - Procedure codes and descriptions of services rendered
  - Charge for each service rendered
  - Provider’s name, address, and tax identification number
  - For prescription drugs, a prescription drug receipt and documentation that includes the patient’s name, date of service, prescription number, name of medication, strength and quantity of medication, prescribing physician’s name, pharmacy name and address, and the cost of medication

* Monthly statements or balance due bills and credit card receipts are not acceptable. Photocopies are only acceptable if you’re covered by two plans and you sent the original bill to the primary payer.

You can get a claim form directly from the applicable claims administrator (see the “Plan Contacts” section at the beginning of this Benefits Book).

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.
### Contacts for post-service claims

<table>
<thead>
<tr>
<th>Benefit option</th>
<th>Contact</th>
<th>Time frame for claim submission</th>
</tr>
</thead>
</table>
| **UnitedHealthcare administered:**  
  • HRA-Based Medical Plan  
  • HSA-Based Medical Plan – Gold  
  • HSA-Based Medical Plan – Silver | 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 “CVS Caremark administered prescription drug benefit:” below. |
| **Anthem Blue Cross Blue Shield administered:**  
  • HRA-Based Medical Plan  
  • HSA-Based Medical Plan – Gold  
  • HSA-Based Medical Plan – Silver  
  • Indemnity Medical Plan | Anthem Blue Cross Blue Shield  
PO Box 105187  
Atlanta, GA 30348  
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 “CVS Caremark administered prescription drug benefit:” below. |
| **HealthPartners administered:**  
  • HRA-Based Medical Plan  
  • HSA-Based Medical Plan – Gold  
  • HSA-Based Medical Plan – Silver | Claims Department  
HealthPartners, Inc.  
PO Box 1289  
Minneapolis, MN 55440-1289 | **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 “CVS Caremark administered prescription drug benefit:” below. |
| **CVS Caremark administered prescription drug benefit:**  
  • HRA-Based Medical Plan  
  • HSA-Based Medical Plan – Gold  
  • HSA-Based Medical Plan – Silver  
  • Indemnity Medical Plan — Anthem | CVS Caremark  
PO Box 52136  
Phoenix, AZ 85072-2136 | Claims must be received no later than 12 months from the date the prescription drug or covered supplies were dispensed. |
<table>
<thead>
<tr>
<th>Benefit option</th>
<th>Contact</th>
<th>Time frame for claim submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully insured medical plans (including Kaiser medical plan options and UnitedHealthcare Global — Expatriate Insurance)</td>
<td>For information, refer to your Evidence of Coverage, Certificate of Coverage, Summary Plan Description, or similar documentation you received for your medical plan.</td>
<td></td>
</tr>
<tr>
<td>Delta Dental:</td>
<td>Delta Dental of Minnesota</td>
<td><strong>In-network services:</strong> 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.</td>
</tr>
<tr>
<td>• Standard</td>
<td>PO Box 622</td>
<td><strong>Out-of-network services:</strong> For services received from out-of-network providers, you are responsible for filing the claim within 12 months from the date of service.</td>
</tr>
<tr>
<td>• Enhanced</td>
<td>Minneapolis, MN 55440-0622</td>
<td></td>
</tr>
<tr>
<td>Vision Service Plan (VSP)</td>
<td>VSP</td>
<td><strong>In-network services:</strong> 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.</td>
</tr>
<tr>
<td></td>
<td>PO Box 385018</td>
<td><strong>Out-of-network services:</strong> For services received from out-of-network providers, you are responsible for filing the claim within six months from the date of service.</td>
</tr>
<tr>
<td></td>
<td>Birmingham, AL 35238</td>
<td></td>
</tr>
<tr>
<td>Health Care FSA Plan:</td>
<td>Claims Administrator — WageWorks</td>
<td>Claims for eligible expenses incurred during the plan year and the grace period must be filed by the following April 30. Refer to “Chapter 5: Health Care Flexible Spending Account Plan (Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)” for more information.</td>
</tr>
<tr>
<td>• Full-Purpose Health Care FSA</td>
<td>PO Box 14053</td>
<td></td>
</tr>
<tr>
<td>• Limited Dental/Vision FSA</td>
<td>Lexington, KY 40512</td>
<td></td>
</tr>
<tr>
<td>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.”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

Initial claims procedures

<table>
<thead>
<tr>
<th>Claim type</th>
<th>You will be notified of a determination:</th>
<th>Extension of time for the claims administrator to make a determination</th>
<th>If the claims administrator needs additional information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service</td>
<td>Within a reasonable period of time, but not later than 15 days after receipt of the claim.</td>
<td>One extension period up to 15 days.</td>
<td>You will have at least 45 days from receipt of the notice to provide the requested information.</td>
</tr>
<tr>
<td>Pre-service involving urgent care</td>
<td>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.</td>
<td>None permitted.</td>
<td>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.</td>
</tr>
<tr>
<td>Concurrent care: To end treatment prematurely or reduce treatment</td>
<td>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.</td>
<td>None permitted.</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Concurrent care: To request extension of treatment</td>
<td>Within a reasonable period of time, but not later than 15 days after receipt of the claim.</td>
<td>One extension period up to 15 days.</td>
<td>You will have at least 45 days from receipt of the notice to provide the requested information.</td>
</tr>
<tr>
<td>Concurrent care involving urgent care</td>
<td>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.</td>
<td>None permitted.</td>
<td>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.</td>
</tr>
<tr>
<td>Post-service</td>
<td>Within a reasonable period of time, but not later than 30 days after receipt of the claim.</td>
<td>One extension period up to 15 days.</td>
<td>You will have at least 45 days to provide the information.</td>
</tr>
</tbody>
</table>
Content of the claim determination notice
Regardless of the type of claim, you will receive a notice of any adverse benefit determination in written or electronic form. The notice will provide the following information:

• The specific reason or reasons for the adverse determination.
• Reference to the specific plan provisions on which the determination is based.
• If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.
• A description of the plan’s claim review procedures and a statement regarding your right to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended (ERISA) Section 502(a) following an adverse benefit determination on appeal.
• If applicable, a statement indicating the internal rule, guideline, or protocol that was relied upon to make the adverse determination and that a copy of such rule will be provided free of charge to you upon request.
• If the adverse determination is based on medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request.
• If the claim is for urgent care, a description of the expedited review process.
• For medical claims, the determination will also include information sufficient to identify the claim involved.
• Any additional information required under applicable law.

Questions about claim determinations
If you have a question or concern about a claim, you may call the claims administrator’s member services department. See the “Plan Contacts” section at the beginning of 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 (a formal appeal) without first calling the claims administrator’s member services department.

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 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 regardless of any verbal discussions 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.

Definitions
Authorized representative
An authorized representative is an individual you have authorized to represent you in the appeal process.

External review process
The external review process is an appeal option available for certain medical claims after the internal claims and appeals review process has been exhausted and the adverse benefit determination has been upheld. The external review is conducted by an independent review organization (IRO).

Internal appeal process
The internal appeal process is the appeal review of an adverse benefit determination conducted by the claims administrator.
**Medical judgment**
Medical judgment includes decisions that are based on the applicable medical plan’s or claims administrator’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; determination that a treatment is experimental or investigational; or as otherwise defined by applicable law. In connection with the external review process, whether an adverse benefit determination involves medical judgment is generally determined by the external reviewer.

**Authorizing a representative**
You have the right to have someone file an appeal on your behalf or represent you in the appeal process.

To authorize someone (including your physician) to represent you through the internal appeal process, most claims administrators require that you submit a written authorization to them. You can call the claims administrator to request an authorization form. If the claims administrator does not require you to complete a specific form, simply submit a written authorization statement with your appeal. Your authorization statement must specify:

- The name and address of the person authorized to represent you
- The purpose for which he or she is 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

Exception: 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 his or her 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 the next page.

**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 notice, regardless of any discussions 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 care claim appeals may be filed verbally. All other claim appeals must be filed in writing.

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 notice. For the address to which an urgent care claim or concurrent care claim appeal should be submitted, refer to the “Contacts for urgent care claim and concurrent care claim appeals” table on page A-14. For the address to which a pre- or post-service claim appeal should be submitted, refer to the “Contacts for pre- and post-service claim appeals” table on page A-15.

The time period for providing notice of an appeal determination varies by the type of claim as described below.

<table>
<thead>
<tr>
<th>Type of claim appeal</th>
<th>You will be notified of a determination:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent care</strong></td>
<td>As soon as possible, but not later than 72 hours from receipt of the appeal</td>
</tr>
<tr>
<td><strong>Pre-service</strong></td>
<td>Within a reasonable period of time, but not later than 30 days from receipt of the appeal</td>
</tr>
<tr>
<td><strong>Concurrent care</strong></td>
<td>In the appeal time frame for pre-service, urgent care, or post-service claims as appropriate to the request</td>
</tr>
<tr>
<td><strong>Post-service</strong></td>
<td>Within a reasonable period of time, but not later than 60 days from receipt of the appeal</td>
</tr>
</tbody>
</table>

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. 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. Send your request to the applicable claims administrator, as noted in the chart below.

<table>
<thead>
<tr>
<th>Claims administrator</th>
<th>Address</th>
</tr>
</thead>
</table>
| UnitedHealthcare     | UnitedHealthcare  
PO Box 30884  
Salt Lake City, UT 84130 |
| Anthem Blue Cross Blue Shield | Anthem Blue Cross Blue Shield  
PO Box 105187  
Atlanta, GA 30348 |
| HealthPartners       | HealthPartners, Inc.  
PO Box 1289  
Minneapolis, MN 55440-1289 |
| CVS Caremark         | CVS Caremark  
PO Box 52136  
Phoenix, AZ 85072-2136 |
| Delta Dental         | Delta Dental of Minnesota  
PO Box 551  
Minneapolis, MN 55440-0551 |
| Vision Service Plan (VSP) | VSP  
PO Box 2350  
Rancho Cordova, CA 95741 |
| WageWorks            | WageWorks, Inc.  
Attn: Claims Department  
1850 W Rio Salado Parkway  
Suite 101  
Tempe, AZ 85281 |

To obtain a copy of the SPD, go to [teamworks.wellsfargo.com](http://teamworks.wellsfargo.com). If you want a copy of the plan document or a print version of the SPD mailed to you, send your written request to the plan administrator by U.S. mail (or overnight delivery such as UPS or FedEx) to:

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

Your written request must identify whether you are requesting a plan document or SPD and must include the Wells Fargo employee’s name, Wells Fargo Employee ID number, the plan name, and calendar year or the date of service of the claim. If you wish for an authorized representative to request and receive a copy of the SPD or plan document on your behalf, an authorization for representation statement must be submitted with the request for the SPD or plan document (see the “Authorizing a representative” section on page A-12 for more information).

You may also request assistance in filing your appeal from your state’s consumer assistance program or ombudsman, if applicable. To determine if your state has such resources, refer to the U.S. Department of Labor website at [dol.gov/ebsa/consumer_info_health.html](http://dol.gov/ebsa/consumer_info_health.html) 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 team member
- Wells Fargo group number and individual member number
- Service provider’s name
- For pre-service, urgent care, or concurrent care claim appeals, the diagnosis and the treatment or service for which approval is being requested
- For post-service appeals, the dates of service, claim number, or both
- An explanation of why you are appealing and your desired resolution
- Written testimony, comments, documents, medical records, or other information to provide clarity or support the appeal (for example, Explanation of Benefits statements, physician statements, previous correspondence, authorization notices, bills, and research)

Refer to the contact tables on the following pages for the location to send your appeal.
## Contacts for urgent care claim and concurrent care claim appeals

<table>
<thead>
<tr>
<th>Benefit option</th>
<th>Contact</th>
</tr>
</thead>
</table>
| **UnitedHealthcare administered:**  
• HRA-Based Medical Plan  
• HSA-Based Medical Plan – Gold  
• HSA-Based Medical Plan – Silver | 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 “CVS Caremark administered prescription drug benefit” below. |
| **Anthem Blue Cross Blue Shield administered:**  
• HRA-Based Medical Plan  
• HSA-Based Medical Plan – Gold  
• HSA-Based Medical Plan – Silver  
• Indemnity Medical Plan | Anthem Blue Cross Blue Shield  
1-866-418-7749  
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 “CVS Caremark administered prescription drug benefit” below. |
| **HealthPartners administered:**  
• HRA-Based Medical Plan  
• HSA-Based Medical Plan – Gold  
• HSA-Based Medical Plan – Silver | HealthPartners  
1-800-331-8643  
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 “CVS Caremark administered prescription drug benefit” below. |
| **CVS Caremark administered prescription drug benefit:**  
• HRA-Based Medical Plan  
• HSA-Based Medical Plan – Gold  
• HSA-Based Medical Plan – Silver  
• Indemnity Medical Plan — Anthem | CVS Caremark  
1-800-772-2301  
1-866-443-1172  
For urgent care claim appeals, specifically state that the appeal is an urgent care claim appeal. |
| **Fully insured medical plans (including 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 you received for your medical plan. |
| **Delta Dental:**  
• Standard  
• Enhanced | Not applicable. For pretreatment estimates, see “Chapter 3: Dental Plan.” |
| **Vision Service Plan (VSP)** | Not applicable. |
| **Flexible spending accounts**  
• Full-Purpose Health Care FSA  
• Limited Dental/Vision FSA | Not applicable. |

*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.”*
## Contacts for pre- and post-service claim appeals

<table>
<thead>
<tr>
<th>Benefit option</th>
<th>Address</th>
</tr>
</thead>
</table>
| UnitedHealthcare administered:  
  • HRA-Based Medical Plan  
  • HSA-Based Medical Plan – Gold  
  • HSA-Based Medical Plan – Silver | UnitedHealthcare  
  Appeals  
  PO Box 740816  
  Atlanta, GA 30374-0816  
  For prescription drug claim appeals, refer to the information in the row titled “CVS Caremark administered prescription drug benefit” below. |
| Anthem Blue Cross Blue Shield administered:  
  • HRA-Based Medical Plan  
  • HSA-Based Medical Plan – Gold  
  • HSA-Based Medical Plan – Silver  
  • Indemnity Medical Plan | Anthem Blue Cross Blue Shield  
  Appeals  
  PO Box 105568  
  Atlanta, GA 30348-5568  
  For prescription drug claim appeals, refer to the information in the row titled “CVS Caremark administered prescription drug benefit” below. |
| HealthPartners administered:  
  • HRA-Based Medical Plan  
  • HSA-Based Medical Plan – Gold  
  • HSA-Based Medical Plan – Silver | Member Service Department  
  HealthPartners, Inc.  
  8170 33rd Avenue South  
  PO Box 1309  
  Minneapolis, MN 55440-1309  
  For prescription drug claim appeals, refer to the information in the row titled “CVS Caremark administered prescription drug benefit” below. |
| CVS Caremark administered prescription drug benefit:  
  • HRA-Based Medical Plan  
  • HSA-Based Medical Plan – Gold  
  • HSA-Based Medical Plan – Silver  
  • Indemnity Medical Plan — Anthem | CVS Caremark  
  Appeals Department  
  MC109  
  PO Box 52084  
  Phoenix, AZ 85072-2084 |
| Fully insured medical plans  
  (including 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 you received for your medical plan. |
| Delta Dental:  
  • Standard  
  • Enhanced | Delta Dental of Minnesota  
  PO Box 551  
  Minneapolis, MN 55440-0551 |
| Vision Service Plan (VSP) | Vision Service Plan  
  Attn: Claim Appeals  
  PO Box 2350  
  Rancho Cordova, CA 95741 |
| Health Care FSA Plan:  
  • Full-Purpose Health Care FSA  
  • Limited Dental/Vision FSA | WageWorks  
  Claim Appeal Board  
  PO Box 991  
  Mequon, WI 53092-0991 |

### 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.”
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 and Limited Dental/Vision FSA, 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

The external review process for medical claim appeals applies only to an adverse benefit determination under the Health Plan that involves medical judgment, as determined by the external reviewer. All other adverse benefit determinations, including a denial, reduction, or a failure to provide payment for a benefit based on a determination that you fail to meet the requirements for eligibility under the terms of the Health Plan, are not eligible for the external review process. For an adverse benefit determination involving a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time), refer to the “Appealing an adverse benefit determination — rescission of coverage” section on page A-19. If the claims administrator issued a final internal adverse benefit determination in response to your internal appeal and that determination was based on medical judgment, or if you have otherwise exhausted the internal claims and appeals process for a claim involving medical judgment, you have the right to request an external review under the following:

- UnitedHealthcare administered:
  - HRA-Based Medical Plan*
  - HSA-Based Medical Plan – Gold*
  - HSA-Based Medical Plan – Silver*
- Anthem Blue Cross Blue Shield administered:
  - HRA-Based Medical Plan*
  - HSA-Based Medical Plan – Gold*
  - HSA-Based Medical Plan – Silver*
  - Indemnity Medical Plan
- HealthPartners administered:
  - HRA-Based Medical Plan*
  - HSA-Based Medical Plan – Gold*
  - HSA-Based Medical Plan – Silver*
- CVS Caremark administered prescription drug benefit:
  - HRA-Based Medical Plan*
  - HSA-Based Medical Plan – Gold*
  - HSA-Based Medical Plan – Silver*
  - Indemnity Medical Plan – Anthem

* Including Out of Area coverage.

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 final adverse benefit determination was based on medical judgment.
  - 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.
- The claims administrator will send out an acknowledgment notice to you within one business day of the preliminary review.
  - If the request for external review is incomplete, the notice will describe the information or materials needed to make the request complete; you must refile your external review request with complete information within 48 hours or within the original four-month filing period, whichever is later.
  - If the request is not eligible for external review, the notification will include the reasons it was not eligible and your right to contact the Department of Labor’s Employee Benefits Security Administration regarding such matters.
- The claims administrator must assign the eligible file to an independent review organization (IRO) accredited by URAC or other similar nationally recognized accrediting organization in accordance with the Patient Protection and Affordable Care Act and applicable regulations.
- The claims administrator will provide the full file to the IRO within five days of assigning the case to it.
- The IRO will send acknowledgment to you that it has been assigned to review your appeal and may offer you the opportunity to present additional information.
• The IRO will review the following types of information and documents received on a timely basis without regard to any previous decisions or conclusions:
  – Your medical records
  – Your attending health care professional’s recommendation
  – Reports from appropriate health care professionals and other documents submitted by the plan, claimant, or provider
  – The terms of the plan under which you have coverage
  – Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, or national or professional medical societies, boards, and associations
  – The IRO’s clinical reviewer’s opinion
  – The plan’s applicable clinical review criteria, unless the criteria are inconsistent with the terms of the plan or with applicable law
• The IRO will issue written notice of the final external review decision to both you and the claims administrator as described under the “External review determinations” section on this page.

**Expedited external reviews**

If you have a medical condition that meets the requirements for an urgent care claim or if the final internal adverse benefit determination concerns admission, availability of care, continued stay, or health care item or service for which you received emergency services and you have not yet been discharged, you may be eligible for an expedited external review.

The difference between an external review and an expedited external review is the time frame allowed for making a determination as noted below.

**External review determinations**

The IRO will notify you and the claims administrator of the final external review determination:

• In writing within 45 days after the IRO receives the request for the standard external review
• Within 72 hours after the IRO receives the request for expedited external review

The determination will contain:

• A general description of the reason for the request
• Information sufficient to identify the claim at issue
• The date the IRO received the assignment to conduct the review

• The date of the IRO’s decision
• A discussion of the principal reason or reasons for its decision, including references to the evidence and documentation reviewed and specific plan provisions and evidence-based standards used in reaching a decision
• A statement that the determination is binding on all parties except to the extent that other remedies may be available under state or federal law
• A statement that judicial review may be available to the claimant
• Current contact information, including phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHS Action section 2793

If the determination is favorable:

• And it is a pre-service appeal, the claims administrator will immediately issue the necessary authorization for the service.
• And it is a post-service appeal, the claims administrator will promptly process the claim for benefits.
• And services were rendered by a network provider, any benefit payment due will be made to the network provider directly.

You remain responsible for any applicable copayment, deductible, and coinsurance under the plan.

If the determination is favorable to you, the decision is binding on all parties except to the extent that other remedies may be available under state or federal law.

If the determination is not favorable to you, no additional benefits are due from the plan and you are responsible for any charges incurred for services received. No further review is available under the appeal process. However, you may have other remedies available under state or federal law, such as filing a lawsuit under Section 502(a) of ERISA.

The determination notice is binding on all parties.
Legal action

No legal action can be taken 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. Refer to the “Agent for service” section in “Appendix B: Important Notifications and Disclosures.”

Appealing an adverse benefit determination — rescission of coverage

Coverage under a medical plan benefit option may be retroactively terminated if a participant (1) performs an act, practice, or omission that constitutes fraud, or (2) makes an intentional misrepresentation of material fact. Retroactive termination under these circumstances is considered a “rescission of coverage.” Wells Fargo Corporate Benefits will provide the participant affected by the rescission of coverage at least 30 days’ advance written notice of termination of coverage.

If an individual’s coverage is retroactively terminated, then the individual may appeal the decision in accordance with the rescission appeal procedures described in the advance written notice. For purposes of these rescission appeal procedures, Wells Fargo Corporate Benefits shall be the named fiduciary and shall have discretionary authority to resolve factual issues and make final determinations with regard to appeals related to rescissions.
Appendix B
Important Notifications and Disclosures

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Your rights under ERISA

All of the Wells Fargo-sponsored plans listed in this book, except for the Wells Fargo & Company Day Care Flexible Spending Account, are subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA gives you rights as a participant in these plans. Note: The individual health savings account you set up separately is not a Wells Fargo-sponsored plan and is not subject to ERISA. For more information on the health savings account, refer to “Appendix C: Health Savings Accounts.”

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 worksites all documents governing the plan, including copies of insurance contracts and the latest Annual Report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration of the U.S. Department of Labor.

• Obtain by written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest Annual Report (Form 5500 Series) and updated Summary Plan Description. The plan administrator may make a reasonable charge for the copies.

• Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue group health plan coverage

You may be entitled to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under a Wells Fargo 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 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 of the 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), these Acts 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 request that a Benefits Book be sent to you free of charge. Contact Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2.

Women’s Health and Cancer Rights Act of 1998

In compliance with the Women’s Health and Cancer Rights Act of 1998, Wells Fargo’s self-insured health plan coverage options provide medical and surgical benefits for mastectomies. 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 deductibles and coinsurance limitations that are consistent with those applicable to other medical and surgical benefits under your health plan coverage option. Call your health plan for more information.

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 her 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) 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: An Introduction to Your Benefits” of this Benefits Book, or contact Team Member Care (formerly known as the HR Service Center) during normal business hours at 1-877-HRWELLS (1-877-479-3557), option 2.

Patient protection notice

Certain Kaiser medical plans may require or allow the designation of a primary care provider, including a pediatrician for your children. You have the right to designate any primary care provider who participates in the plan’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating providers:
primary care providers, contact Kaiser Permanente; for the applicable phone number, see the Kaiser plans listed in the “ERISA plans sponsored by Wells Fargo” table starting on page B-6.

In addition, for all of our plans, you do not need prior authorization to obtain access to obstetrics or gynecology providers. Your 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.

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-6 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-6. Please use the address below for any correspondence to the plan sponsor and include the plan name and plan number:

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

Plan administrator

Information about the plan administrator for the Salary Continuation Pay Plan is listed in the “Plan administrator” section on page 12-12 of this Benefits Book.

The plan administrator for all other plans listed in the “ERISA plans sponsored by Wells Fargo” table starting on page B-6, for purposes of ERISA §3(16)(A), is the Director of Human Resources, the Director of Compensation and Benefits, and the Head of Enterprise HR Solutions of the Company, each of whom, acting individually or jointly, may take action as the plan administrator for the respective plan. The plan administrator has full discretionary authority to administer and interpret those plans. The plan administrator may delegate duties and authority to others to accomplish those duties.

The plan administrator’s address is:

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

To contact the plan administrator, you may also call Team Member Care (formerly known as the HR Service Center) 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-6 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 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
- MAC D1053-300
- 301 South College Street
- Charlotte, NC 28202

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-6.

No legal action can be taken to recover expenses until the applicable claims and appeals procedures have been exhausted. Any suit for benefits must be brought within one year of the date of the final appeal determination unless otherwise noted in the applicable chapter of this Benefits Book.

Plan trustee

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

- Wells Fargo Bank, N.A.
- MAC N9310-085
- 550 S. 4th Street
- Minneapolis, MN 55415

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.
Authorization to deduct contributions and premiums from payroll

By making your benefit elections (including default or automatic elections) for yourself and your dependents as part of the benefit enrollment process, you authorize your employer to deduct from your pay the necessary contribution and premium amounts for the benefit coverage you elected under the various Wells Fargo & Company employee benefit plans, including deducting from your pay any back contributions or premiums for coverage for which you may be in arrears, to the extent permitted by applicable law.

Disclaimer statement regarding 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 at 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.

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 team members 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 Salary Continuation Pay Plan, see the “Plan administrator” section on page 12-12 in “Chapter 12: Salary Continuation Pay Plan” of this Benefits Book. For the plan administrator’s address for other plans covered in this Benefits Book, see the “Plan administrator” section on page B-4.

Future of the plans

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

Plan amendments

Wells Fargo & Company, by action of its Board of Directors, the Human Resources Committee of the Board of Directors, or that of a person so authorized by resolution of the Board of Directors or the Human Resources Committee, may amend the plans at any time. In addition, Wells Fargo & Company’s Director of Human Resources, Wells Fargo & Company’s Director of Compensation and Benefits, or Wells Fargo & Company’s Head of Enterprise HR Solutions may amend the plans as required by the IRS or ERISA and make changes in the administration or operation of the plans, including authorizing plan mergers.

Plan termination

Wells Fargo & Company may discontinue any benefits plan by action of Wells Fargo’s Board of Directors or as authorized by the plans. Wells Fargo & Company may terminate participation of a participating employer by written action of the Director of Human Resources, the Director of Compensation and Benefits, or Wells Fargo & Company’s Head of Enterprise HR Solutions.
## ERISA plans sponsored by Wells Fargo

<table>
<thead>
<tr>
<th>Plan name</th>
<th>Plan coverage option</th>
<th>Plan number</th>
<th>Service provider or insurer</th>
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| Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)¹ | Health Reimbursement Account (HRA)-Based Medical Plan (Self-insured²) | 537         | **Medical**  
  Anthem Blue Cross Blue Shield  
  1-866-418-7749  
  HealthPartners  
  1-888-487-4442  
  UnitedHealthcare  
  1-800-842-9722  
  **Prescriptions**  
  CVS Caremark  
  1-800-772-2301 |
| Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)¹ | Health Savings Account (HSA)-Based Medical Plan - Gold (Self-insured²) | 537         | **Medical**  
  Anthem Blue Cross Blue Shield  
  1-866-418-7749  
  HealthPartners  
  1-888-487-4442  
  UnitedHealthcare  
  1-800-842-9722  
  **Prescriptions**  
  CVS Caremark  
  1-800-772-2301 |
| Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)¹ | Health Savings Account (HSA)-Based Medical Plan - Silver (Self-insured²) | 537         | **Medical**  
  Anthem Blue Cross Blue Shield  
  1-866-418-7749  
  HealthPartners  
  1-888-487-4442  
  UnitedHealthcare  
  1-800-842-9722  
  **Prescriptions**  
  CVS Caremark  
  1-800-772-2301 |
| Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)¹ | Indemnity Medical Plan — Anthem BCBS (Self-insured²) | 537         | **Medical**  
  Anthem Blue Cross Blue Shield  
  1-866-418-7749  
  **Prescriptions**  
  CVS Caremark  
  1-800-772-2301 |

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 Health 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.
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<th>Plan number</th>
<th>Service provider or insurer</th>
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<td>HMO — Kaiser Northern California (Insured)&lt;sup&gt;4&lt;/sup&gt;</td>
<td>537</td>
<td>Kaiser Permanente 1-800-464-4000</td>
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<td>HMO — Kaiser Southern California (Insured)&lt;sup&gt;4&lt;/sup&gt;</td>
<td>537</td>
<td>Kaiser Permanente 1-800-464-4000</td>
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<td>Wells Fargo &amp; Company Health Plan (for Eligible Active Employees and Their Dependents)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>HMO — Kaiser Colorado (Insured)&lt;sup&gt;4&lt;/sup&gt;</td>
<td>537</td>
<td>Kaiser Permanente Denver/Boulder area 303-338-3800 Colorado Springs area 1-888-681-7878</td>
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<tr>
<td>Wells Fargo &amp; Company Health Plan (for Eligible Active Employees and Their Dependents)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>POS Kaiser Added Choice — Hawaii (Insured)&lt;sup&gt;4&lt;/sup&gt;</td>
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<td>HMO — Kaiser Northwest (Insured)&lt;sup&gt;4&lt;/sup&gt;</td>
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<td>Kaiser Permanente 1-800-813-2000 Portland metro area 503-813-2000</td>
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<td>High-Deductible Health Plan (HDHP) — Kaiser Southern California (Insured)&lt;sup&gt;3&lt;/sup&gt;</td>
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<td>Kaiser Permanente 1-800-464-4000</td>
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<td>Wells Fargo &amp; Company Health Plan (for Eligible Active Employees and Their Dependents)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>High-Deductible Health Plan (HDHP) — Kaiser Colorado (Insured)&lt;sup&gt;3&lt;/sup&gt;</td>
<td>537</td>
<td>Kaiser Permanente Denver/Boulder area 303-338-3800 Colorado Springs area 1-888-681-7878</td>
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<td>High-Deductible Health Plan (HDHP) — Kaiser Northwest (Insured)&lt;sup&gt;3&lt;/sup&gt;</td>
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<td>Kaiser Permanente 1-800-813-2000 Portland metro area 503-813-2000</td>
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<td>Wells Fargo &amp; Company Health Plan (for Eligible Active Employees and Their Dependents)&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>Delta Dental of Minnesota 1-877-598-5342</td>
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<td>VSP 1-877-861-8352</td>
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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 Health 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.
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<td>UnitedHealthcare Global</td>
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<td>Limited Dental/Vision Flexible</td>
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<td>WageWorks, Inc.</td>
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<td>Short-Term Disability Plan (STD)</td>
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<td>Liberty Life Assurance Company of Boston</td>
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<td>Plan</td>
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<td>Wells Fargo &amp; Company Life Insurance Plan</td>
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<td>1-800-638-6420</td>
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<tr>
<td></td>
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<td>Charlotte, NC 28282-1915</td>
</tr>
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</table>

4. “Insured” means benefits are fully insured and paid for by the insurer, which may be an HMO.
## Appendix C

### Health Savings Accounts

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Introduction

Please note that this appendix is included in the overall Benefits Book solely for your convenience. Although this appendix provides you with information regarding health savings accounts (HSAs), this appendix itself is not part of the official Summary Plan Description ( SPD) for the Wells Fargo & Company Health Plan (or its benefit options, including the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver (including Out of Area options), and HDHP — Kaiser medical plans) or for any ERISA-covered employee benefit plans maintained by Wells Fargo & Company.

This appendix to the Benefits Book describes some key features of the HSA that you can open in conjunction with a high-deductible health plan, such as the HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver (including Out of Area options), and HDHP — Kaiser medical plans. In particular, and except as otherwise indicated, this appendix will address the HSA and not the associated high-deductible health plans. The HSA-Based Medical Plan – Gold or HSA-Based Medical Plan – Silver (including Out of Area options), and HDHP — Kaiser medical plans are generally referred to in this appendix as “HSA-compatible medical plans.”

Optum Bank provides certain HSA administrative services.

Wells Fargo does not insure the HSAs described in this appendix. It is Wells Fargo’s intention to comply with U.S. Department of Labor guidance set forth in Field Assistance Bulletin Numbers 2004-01 and 2006-02, which specifies that an HSA is not subject to ERISA when the employer’s involvement is limited.

Establishment of an HSA is completely voluntary on your part:

• Wells Fargo does not limit your ability to move your funds to another HSA or impose conditions on usage of HSA funds beyond those permitted under the Internal Revenue Code of 1986. However, Wells Fargo will only support ongoing payroll deductions and provide funding of health and wellness dollars 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 your tax advisor.

Who is eligible to open and contribute to an HSA

Who is eligible to contribute to an HSA

You must be covered under one of the Wells Fargo-sponsored high-deductible health plans to contribute to an HSA. Eligibility to participate in the HSA-compatible medical plans is described in “Chapter 1: An Introduction to Your Benefits” in this Benefits Book.

You cannot contribute to an HSA if:

• You are covered under a non-HSA-compatible medical plan. Note that coverage under a “general purpose” health care flexible spending account (FSA) or health reimbursement account (HRA) through Wells Fargo or your spouse’s employer is disqualifying coverage. In addition, individuals covered as dependents under a parent’s “general purpose” health care FSA or HRA are not eligible to contribute to an HSA. A “general purpose” FSA or HRA covers more than dental, vision, preventive care, or post-deductible expenses.

By contrast, coverage under a vision, dental, or other plan designated as permitted insurance by the IRS will not make you ineligible to contribute to an HSA. This means that coverage under a “limited purpose” FSA or HRA will not make you ineligible. A “limited purpose” FSA or HRA typically covers only dental, vision, preventive care, or post-deductible expenses.

• You are entitled to benefits under Medicare (that is, you are enrolled in Medicare).

• You are eligible to be claimed as a dependent on another person’s tax return. Please note that generally a spouse is not considered a dependent for this purpose.

• You have received medical benefits from the Department of Veteran Affairs (VA) at any time during the previous three months (with an exception starting in 2016 for receipt of VA hospital care or medical services in connection with a service-related disability).

• You have received medical services at an Indian Health Service (IHS) facility at any time during the previous three months.

Note: You are responsible for determining if you are eligible to contribute to an HSA. Consult your 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
How to open an HSA
If you enroll in one of the HSA-compatible medical plans sponsored by Wells Fargo and do not already have an HSA with Optum Bank, Wells Fargo will facilitate opening an HSA with Optum Bank for you. To open an HSA with Optum Bank, you must:

- Have a physical address as your home address.
- Provide Wells Fargo benefits with a home phone number.
- Appoint Wells Fargo & Company as your agent for account opening purposes as part of the online enrollment process.

Please be aware that HSAs are standard bank accounts and, as such, are subject to standard risk and customer due diligence screening both before being opened and during the life of the account. In some circumstances, Optum Bank may request additional information from you or Wells Fargo Corporate Benefits to open your HSA. It is possible that Optum Bank could decline to open your HSA or could close your HSA. You will receive additional information from Optum Bank once they have opened your HSA.

Contributions

Contribution limits
The contribution limits for individual and family high-deductible health plan coverage are set by federal law.

- For the 2018 tax year, the maximum HSA contribution is:
  - $3,450 for people with individual coverage
  - $6,900 for people with family coverage
- 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 you may have the opportunity to earn health and wellness dollars, the Wells Fargo maximum HSA employee annual payroll contribution amounts for 2018 are:

- $2,650 You only
- $5,300 You + spouse or domestic partner
- $6,100 You + children
- $5,300 You + spouse or domestic partner + children

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. For more information on making contributions to an HSA outside of payroll, refer to the “Contributing through Optum Bank” section on page C-5 of this appendix.

For more information about the maximum limits set by law, see the IRS website at www.irs.gov.

Your personal contribution limit may be lower than the maximum contribution limits listed above. Contribution limit rules are complex and should be carefully considered. For example, 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 your tax advisor to determine how midyear eligibility changes affect your contribution limit.

Note: Amounts that exceed your personal contribution maximum are not tax-deductible and will be subject to a 6% excise tax. This excise tax can be avoided if you withdraw the excess contribution (and net income attributable to such contribution) before the last day for filing your federal income tax return for the year (generally April 15 of the following year).

If you have contributed amounts in excess of the allowable maximum contribution, please call Optum Bank Customer Care at 1-844-326-7967.

Wells Fargo does not monitor whether you have exceeded your personal contribution limit. You are solely responsible for monitoring your personal contribution limit. Consult your tax advisor with questions.

Making payroll contributions
You can make contributions to your HSA through payroll deductions on a before-tax basis. You can make an HSA contribution election during your designated enrollment period or the Annual Benefits Enrollment period. You can also make or change your HSA contribution election by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, anytime throughout the year. 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. You may, however, change how your contribution is distributed over pay periods, as described in the “HSA contribution flexibility” section on page C-5.
Note: If coverage under an HSA-compatible medical plan terminates, no further payroll contributions may be made to your HSA.

**HSA contribution flexibility**

You have the flexibility to select the pay periods from which your annual HSA contribution election is taken.

Once you make your annual HSA contribution election, you can allocate your contribution over specific pay periods by using the Manage Health Savings Account Deductions tool in Your Benefits on Teamworks anytime throughout the year.

If you change your annual HSA contributions election midyear by calling Team Member Care (formerly known as the HR Service Center), any payroll contributions and pay dates you originally selected going forward will be canceled. Your annual HSA contribution election will be divided evenly over the remaining pay periods for the year. If you want to select pay dates from which your new HSA contribution election will be taken, you will need to use the Manage Health Savings Account Deductions tool in Your Benefits on Teamworks.

More information on this process is provided on the Manage Health Savings Account Deductions tool in Your Benefits on Teamworks.

**Catch-up contributions**

If you are age 55 or older during the 2018 calendar year and are otherwise eligible to contribute to an HSA, you can make an additional $1,000 payroll contribution on a before-tax basis. This contribution is often referred to as a “catch-up contribution.” If you elect to make a catch-up contribution through payroll deduction, the amount will be divided by the number of remaining pay periods, unless you adjust the payroll contribution election by using the Manage Health Savings Account Deductions tool in Your Benefits on Teamworks.

More information on this process is provided on the Manage Health Savings Account Deductions tool in Your Benefits on Teamworks.

**Full-Purpose Health Care FSA grace period**

Important: If you were enrolled in the 2017 Full-Purpose Health Care Flexible Spending Account (FSA) and had a balance in that account on December 31, 2017, you cannot contribute to your HSA until April 2018. That means that neither you nor Wells Fargo can make contributions toward your HSA (including earned health and wellness dollars) until April 1, 2018.

**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.”

**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/wellsfargo.

All funds placed into your HSA are owned and controlled by you and subject to the terms and conditions of the Custodial and Deposit Agreement provided by Optum Bank.

**Qualified medical expenses**

The funds in your HSA will be available to help you pay your or your eligible dependents’ out-of-pocket costs, including annual deductibles and coinsurance under an HSA-compatible medical plan. You may also use your HSA funds to pay for medical care that is not covered under an HSA-compatible medical plan but is eligible under Section 213(d) of the Internal Revenue Code of 1986 (“the Code”), as amended from time to time. Expenses that are for “medical care” under Section 213(d) of the Code are “qualified medical expenses.” HSA funds used for such purposes are not subject to income or excise taxes.

Qualified medical expenses only include your and your eligible dependents’ medical expenses, meaning your spouse and any other family members 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/wellsfargo. 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 your 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 or liable 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.) In addition, with the exception of insulin, you cannot use HSA funds to reimburse expenses for over-the-counter medicines and drugs unless you have a prescription.

Additional information about the HSA

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will carry over to the following year. If your employment terminates for any reason or your enrollment in an HSA-compatible medical plan ends, you will continue to own and control the funds in your HSA, whether or not you elect COBRA coverage for the HSA-compatible medical plan, as described in this Benefits Book.

If you choose to roll over the HSA funds to another HSA trustee or custodian, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds.

You will need to make sure to update any personal home address changes after your initial enrollment with Optum Bank. You are responsible for notifying Optum Bank directly of any changes and for all maintenance of the HSA.

Wells Fargo pays the monthly service fee for the HSA as long as you are enrolled in a Wells Fargo HSA-compatible medical plan. The HSA must be opened through the Wells Fargo-designated HSA administrator, Optum Bank. Wells Fargo does not pay other fees associated with the HSA, as outlined in the Schedule of Fees and Custodial and Deposit Agreement provided in your welcome kit or available on the Optum Bank website at https://www.optumbank.com/wellsfargo. You will be responsible for the monthly service fee and all other fees for your HSA if you are no longer enrolled in a Wells Fargo HSA-compatible medical plan.

You can obtain additional information about HSA online at https://www.irs.gov/publications/p969/ar02.html#en_US_publink1000204020 or at https://www.optumbank.com/wellsfargo. You may also contact your tax advisor. Optum Bank Customer Care can be contacted at 1-844-326-7967.

Note: The tax rules for HSAs are complex. This appendix only describes some of the rules. You should review information provided by Optum Bank and the IRS, as well as the Code provisions for HSAs. Wells Fargo does not provide tax advice, and you may want to consult with your 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, you may remain eligible to participate in the Wells Fargo-sponsored benefit plans described in this Benefits Book during a leave of absence, but how 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 administration of benefits.

Please refer to the Team Member Handbook on Teamworks for more information about the various types of leave offered by Wells Fargo. You may also call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, 3. Please note that the policies contained in the Team Member Handbook do not govern Wells Fargo-sponsored benefit plans.

The information in this paragraph is for informational purposes only and is not part of any Summary Plan Description. Other programs not described in this Benefits Book may be impacted by your leave of absence (such as the Commuter Benefit Program). Refer to Teamworks for details and any actions you may be required to take. The policies related to any such programs do not govern Wells Fargo-sponsored benefit plans described in this Benefits Book.

Eligibility to participate in benefits during leaves of absence

Eligibility to participate

Subject to exceptions described below, eligibility to participate in the following voluntary benefit options generally continues during a leave of absence as long as you continue to pay the required applicable contribution or premium:

• Medical
• Dental
• Vision
• Full-Purpose Health Care FSA*
• Limited Dental/Vision FSA*
• Day Care FSA*
• Life Insurance (Optional Term Life, Spouse/Partner Optional Term Life, and Dependent Term Life coverages)
• Accidental Death and Dismemberment
• Optional Long-Term Disability
• Legal Services

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
• Basic Long-Term Disability

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, Military Leave, unpaid Administrative Leave, or Salary Continuation Pay Leave, eligibility to participate or be enrolled in the following benefit options terminates:

• Basic Long-Term Disability
• Optional Long-Term Disability

* 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).

• Your leave of absence may be protected by the Family Medical Leave Act (FMLA). If your leave is protected by FMLA, please refer to the “Family Medical Leave Act (FMLA)” section on page D-6 for applicable information.
If you are on a Job Search Leave, Military Leave, unpaid Administrative Leave, or Salary Continuation Pay Leave, eligibility to participate or be enrolled in the following benefit option terminates:

• Short-Term Disability

If you have questions or to obtain more information, contact Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, 3.

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 benefits-eligible 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 benefits-eligible position. Your payroll deductions will be adjusted for the rest of the plan year to account for any applicable missed contributions while you were on leave. 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 under Parental Leave, Critical Caregiving Leave, short-term disability benefits under the Wells Fargo & Company Short-Term Disability Plan, or benefits under the Texas Injury Benefits Plan) and your claim is approved, all of your applicable contributions and premiums for elected benefits will automatically be deducted from your income replacement benefit.

If the amount of income replacement you receive is not sufficient to cover past due and/or current benefit deductions, then the past due benefit deductions and contributions are taken first. If, after this, there is not sufficient income replacement to cover the current benefit deductions and contributions, then current deductions will not be taken and will become past due.

If benefit deductions are not taken for two consecutive payroll periods, you may be placed on a direct billing process. Once the direct billing process is established for you, you must continue to pay for your applicable benefit elections through the direct billing process until you return from your leave to your regular work schedule. See the “Direct billing process” section on page D-4 for more information.

If another entity provides income replacement, such as through 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 on page D-4 for more information on how to pay for continued benefits.
Leaves without recognized sources of income replacement
If you do not make a claim for Wells Fargo’s recognized sources of income replacement benefits, or if your claim for such recognized sources of income replacement benefits is denied, or if your income replacement is not a recognized source of income replacement for the purposes of benefit deductions, how you pay to preserve coverage depends on the length of your leave. If your leave of absence is less than six weeks, contributions or premiums that accumulated during your leave will be deducted from your pay upon your return from leave. However, if your leave of absence lasts six weeks or more, you will be set up on the direct billing process. Once the direct billing process is established for you, you must continue to pay for your applicable benefit elections through direct billing until you return from your leave to your regular work schedule. See the “Direct billing process” section starting on this page 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
  – Then, to currently due contributions or premiums
• Dental coverage
  – Payments are first applied to past due contributions or premiums
  – Then, to currently due contributions or premiums
• Vision coverage
  – Payments are first applied to past due contributions or premiums
  – Then, to currently due contributions or premiums

Also, if you make a partial payment for either medical, dental, or vision coverage and the balance owed after the due date does not exceed the lesser of 10% of the monthly amount billed or $50 (separately for each medical, dental, and vision contribution or premium), you will have additional time to make payment in full.

If the monthly balance for these benefits exceeds the lesser of 10% or $50 after 60 days (from the first billing date for these charges), coverage may end on the last day of the month for which the last full payment was received (partial payment will be refunded).

Payments for all other benefits coverage
After payments have been applied to medical, dental, and vision coverage as noted above, payments are then applied to all other benefits in the order they are billed on the billing statement, generally: Optional Term Life, Accidental Death and Dismemberment, Dependent Term Life, Spouse/Partner Term Life, Legal Services Coverage, and Optional Long-Term Disability, 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 will be refunded).

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), and 50% of dental premiums, your dental benefits coverage would end on the last day of the month in which the remaining balance owed is greater than the lesser of 10% of the monthly amount billed or $50, and any partial payments received covering dental premiums would be refunded. Legal benefits would end on the last day of the month for which the balance was not 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 these benefit options 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) even though contributions are not being taken. If you participate in the Day Care FSA, generally, you cannot claim expenses incurred during your leave. To be eligible for reimbursement under the Day Care FSA, the day care expenses must be incurred so you can work or look for work. For more information on flexible spending accounts, see “Chapter 5: Health Care Flexible Spending Account Plan (Full-Purpose Health Care Flexible Spending Account and Limited Dental/Vision Flexible Spending Account)” or “Chapter 6: Day Care Flexible Spending Account.”
Termination of benefits coverage for nonpayment

For information regarding the impact of a lapse of coverage under your benefit options, please see the applicable chapter in this Benefits Book.

If your benefits coverage is terminated due to nonpayment, reinstatement options for the benefit plans vary when you return to work in a benefits-eligible position immediately following your leave. For information, see the “Returning from a leave of absence” section starting on this page.

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 benefits-eligible position immediately following your leave, your benefit elections will continue upon your return to work and the corresponding cost for coverage will be deducted from your pay, including any back contributions or premiums owed, unless your coverage was terminated for nonpayment.

Note: Missed FSA contributions will only be deducted from your pay for the current plan year FSA election when you return to work.

If your leave type resulted in termination of coverage for Short-Term Disability or Long-Term Disability, upon the commencement of your leave, when you return to work in a benefits-eligible position immediately following your leave, your enrollment in the Short-Term Disability 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 11: 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 in a benefits-eligible position immediately following your leave, generally, you will have to wait until the next Annual Benefits Enrollment period to make benefit elections (subject to all enrollment provisions of the plans and benefit options). Please note the following:

• You may reenroll in medical, dental, vision, or legal services coverage 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: An Introduction to Your Benefits.”

• For the Full-Purpose Health Care FSA or Limited Dental/Vision FSA, if you return to work during the same plan year in a benefits-eligible position, your payroll deductions will begin again and will be adjusted for the rest of the plan year to account for any applicable missed contributions while you were on leave. 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, refer to “Chapter 6: Day Care Flexible Spending Account.”

• If you want to reenroll for Optional Term Life Insurance coverage, Spouse/Partner Optional Term Life Insurance coverage, or Dependent Term Life Insurance coverage, you will be required to submit a completed Statement of Health form through the late enrollment process. Refer to the applicable chapter in this Benefits Book for more information on the late enrollment process.

• For information about reinstatement of Optional Long-Term Disability, see “Chapter 11: 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

If your employment ends during your leave of absence or at the end of a leave of absence and your benefit coverage was not terminated while on leave, you must make the required payments through direct billing for all missed benefit deductions that occurred during your leave of absence. If you fail to make the required payments as described in the “Direct billing process” section starting on page D-4, your coverage will end on the last day of the month for which the last full payment was received. If your coverage terminates due to nonpayment, you may lose eligibility for COBRA continuation (only for benefit options subject to COBRA).
Family Medical Leave Act (FMLA)

Certain leaves of absence may be protected under the Family Medical Leave Act (FMLA). If your leave is protected under FMLA, Wells Fargo will continue to maintain your benefits coverage and provide for applicable reinstatement of coverage when you return to work to the extent required by FMLA.

For more information on FMLA protection, refer to the Team Member Handbook or call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, 3. Please note that the policies contained in the Team Member Handbook do not govern Wells Fargo-sponsored benefit plans.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Benefits coverage while you are on Military Leave

Medical, dental, vision, legal services, accidental death and dismemberment, and life insurance coverage can continue through the first 24 months of your approved Military Leave to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), provided that you continue to pay your contributions or premiums and have not voluntarily dropped your coverage. You may also continue your Full-Purpose Health Care FSA or your Limited Dental/Vision FSA for the remainder of the current plan year.

Note: Your eligibility for coverage under the Short-Term Disability Plan 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 Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, 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 Team Member 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, upon your reemployment after Military Leave in a benefits-eligible position, 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. You must have been on leave greater than 31 days for either of these options to apply. Please call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, 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:

- Medical
  - If you change medical plans mid-year or enroll in a medical plan mid-year, you will be required to meet the applicable full year annual deductible and out-of-pocket maximum under the newly elected plan option. For more information on mid-year enrollments, see the applicable section in “Chapter 2: Medical Plans.”
  - If you are considering electing coverage in a high-deductible health plan with a corresponding health care savings account (HSA), please review the “Who is eligible to contribute to an HSA” section on page C-3 and other information within “Appendix C: Health Savings Accounts” before making your election. Appendix C is solely for your convenience and is not part of any Summary Plan Description for any ERISA-covered employee benefit plans maintained by Wells Fargo & Company.
• Dental
• Vision
• Full-Purpose Health Care FSA or Limited Dental/Vision FSA, as applicable
• Day Care FSA
• Accidental Death & Dismemberment Plan
• Legal Services Plan
• Life Insurance
  – Team Member Optional Term Life — enroll for the first time at 1x covered pay¹ or increase previously elected coverage by 1x covered pay¹,²
  – Spouse/Domestic Partner Optional Term Life — enroll for the first time at $25,000¹ or increase previously elected coverage by $25,000¹,²
  – 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 date in a benefits-eligible position provided you enroll or reenroll within 60 days of your reemployment date.

**IMPORTANT:** If you continued your benefits coverage while on Military Leave and return to work within 24 months and do not make new benefit elections upon your reemployment, you will continue to be enrolled in the benefit options you paid for while on Military Leave.

Different processes apply for reinstatement or enrollment in disability coverage upon your reemployment as described below:

• Your enrollment in the Short-Term Disability 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. Coverage will be effective upon your reemployment. If you don’t want your coverage reinstated, you must call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, 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; you must call Team Member 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, see the “Late enrollment” section on page 11-4 in “Chapter 11: 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: An Introduction to Your Benefits.”

**For more information**

For more information on USERRA, refer to the Team Member Handbook or call Team Member Care at 1-877-HRWELLS (1-877-479-3557), option 2, 2. Please note that the policies contained in the Team Member Handbook do not govern Wells Fargo-sponsored benefit plans.

For more information about the Wells Fargo-sponsored benefit plans, including the impact of a lapse of coverage under your benefit options, see the chapter that applies to the benefit options in this Benefits Book.
Appendix E

Continuing Coverage Under COBRA

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Federal law requires that the Wells Fargo group health plans give covered team members and their families the opportunity to continue their health care coverage when there is a qualifying event that would result in a loss of coverage under the applicable Wells Fargo group health plan (the Plan). As used in the “COBRA general notice” section below and in the “COBRA administrative information” section starting on page E-4, the term “group health plan” means the medical (including the prescription drug benefit), dental, and vision benefit options under the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents), the Wells Fargo & Company Health Care Flexible Spending Account Plan, and the Wells Fargo & Company International Plan. Depending on the type of qualifying event, qualified beneficiaries can include Wells Fargo team members covered under a group health plan, their covered spouses or domestic partners, and dependent children. Generally, a qualified beneficiary is someone who will lose coverage under a group health plan because of a qualifying event. In this section, Wells Fargo team members are referred to as “you” or “participants.”

COBRA general notice

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the applicable Summary Plan Description including the “COBRA administrative information” section starting on page E-4 or contact the Plan Administrator.

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.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” 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 spouse or a domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

• Your hours of employment are reduced
• Your employment ends for any reason other than gross misconduct

If you’re the spouse or a domestic partner of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

• Your spouse or domestic partner’s (the Wells Fargo employee under whom you have dependent coverage) hours of employment are reduced
• Your spouse’s or domestic partner’s (the Wells Fargo employee under whom you have dependent coverage) death
• Your spouse’s or domestic partner’s (the Wells Fargo employee under whom you have dependent coverage) employment ends for any reason other than his or her gross misconduct
• You become divorced or legally separated from your spouse or your domestic partnership or civil union is terminated

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

• The parent-employee’s (the Wells Fargo employee under whom the child is covered as a dependent) death
• The parent-employee’s (the Wells Fargo employee under whom the child is covered as a dependent) hours of employment are reduced
The parent-employee’s (the Wells Fargo employee under whom the child is covered as a dependent) employment ends for any reason other than his or her gross misconduct.

The parents become divorced or legally separated (applies to the Wells Fargo employee’s stepchildren only).

The child stops being eligible for coverage under the Plan as a “dependent child”

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment
- Death of the employee

For all other qualifying events (divorce or legal separation of the employee and a spouse, termination of a domestic partnership or civil union of the employee and partner, or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice by calling Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2.

How is COBRA continuation coverage provided?
Once the Plan 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, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

- Disability extension of 18-month period of continuation coverage. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must timely notify BenefitConnect™ | COBRA of a disability and provide a copy of Social Security’s disability determination to extend the period of COBRA continuation coverage. You can call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers only]. 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. For more information, see the “Social Security disability extension” section on page E-8.

- Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse or domestic partner and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan 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 the employee or former employee dies, or gets divorced or legally separated (or there is a termination of a domestic partnership or civil union), or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or domestic partner or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For more information, see the “Secondary qualifying event” section on page E-8.

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, Medicaid, 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.
If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers 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 (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.

Keep your Plan informed of address changes

To protect your family’s rights, let Team Member Care (formerly known as the HR Service Center) know about any changes in addresses of family members. Once enrolled in COBRA, let BenefitConnect™ | COBRA know about any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For more information about COBRA continuation coverage and the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents), the Wells Fargo & Company Health Care Flexible Spending Account Plan, and the Wells Fargo & Company International Plan:

- Visit https://cobra.ehr.com
- Call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers only]
- Send a written request to:
  
  BenefitConnect | COBRA
  
  PO Box 5884
  
  Hopkins, MN 55343-5884

COBRA administrative information

General information

Federal law requires that the Wells Fargo group health plans give covered team members and their families the opportunity to continue their health care coverage when there is a qualifying event that would result in a loss of coverage under the applicable Wells Fargo group health plan. As used in the “COBRA general notice” section on page E-2 and in this administrative information section, 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, the Wells Fargo & Company Health Care Flexible Spending Account Plan, and the Wells Fargo & Company International Plan. Depending on the type of qualifying event, qualified beneficiaries can include Wells Fargo team members covered under a group health plan, their covered spouses or domestic partners, and dependent children. Generally, a qualified beneficiary is someone who will lose coverage under a group health plan because of a qualifying event. In this section, Wells Fargo team members are referred to as “you” or “participants.”

COBRA continuation coverage is the same coverage that the Wells Fargo group health plans give to other similarly situated participants and beneficiaries who are not receiving COBRA continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under a Wells Fargo group health plan as other plan participants, including Annual Benefits Enrollment and special enrollment rights.

Note: If you or a dependent is entitled to Medicare at the time you are offered COBRA continuation coverage or while enrolled under COBRA, you or your dependent should consider enrolling in Medicare when first eligible. Delaying enrollment in Medicare may result in late enrollment penalties or surcharges. For more information on enrolling in Medicare and any late enrollment penalties or surcharges that may be imposed by the federal government, refer to medicare.gov or call Medicare at 1-800-633-4227.
Coverage and eligibility rights
Plan coverage may be continued through COBRA continuation coverage only for those individuals who were covered by the applicable group health plan at the time the qualifying event occurred. Each individual has the right to elect coverage regardless of what the team member or other covered dependents choose.

New dependent eligibility and rights
Newly eligible dependents may be added to coverage after the initial COBRA qualifying event, provided that they meet the eligibility requirements and are enrolled within 60 days of becoming eligible. However, except for newborn or newly adopted children, dependents added after the qualifying event may only be covered with a person who had COBRA rights at the time of the qualifying event. They may not extend coverage individually because they are not qualified beneficiaries in their own right. Newly born or adopted children who become dependents after the qualifying event do have these continuation rights individually as qualified beneficiaries.

Adding a new dependent
To enroll newly eligible dependents in COBRA, you must notify BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers 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 a team member who are receiving benefits under the medical plan pursuant to a Qualified Medical Child Support Order (QMCSO) are entitled to the same rights under COBRA as a dependent child of a covered team member.

Primary qualifying events
The following events may allow a team member or a dependent to continue coverage when it would otherwise end:

<table>
<thead>
<tr>
<th>Wells Fargo team member</th>
<th>Spouse or domestic partner</th>
<th>Dependent children</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduction in hours of employment results in ineligibility</td>
<td>• Team member's reduction in hours results in ineligibility</td>
<td>• Team member's reduction in hours results in ineligibility</td>
</tr>
<tr>
<td>• Termination</td>
<td>• Termination of team member</td>
<td>• Termination of team member</td>
</tr>
<tr>
<td>• Retirement</td>
<td>• Retirement of team member</td>
<td>• Retirement of team member</td>
</tr>
<tr>
<td></td>
<td>• Divorce, legal separation, or termination of a domestic partnership or civil union</td>
<td>• Divorce, legal separation (for the Wells Fargo employee's stepchildren only), termination of a domestic partnership or civil union (for children of domestic partner)</td>
</tr>
<tr>
<td></td>
<td>• Death of team member</td>
<td>• Death of team member</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Loss of dependent status</td>
</tr>
</tbody>
</table>
Your notification responsibilities — primary qualifying events

COBRA continuation coverage will be offered to covered participants and qualified beneficiaries once the COBRA administrator has been notified that a qualifying event has occurred. Wells Fargo will have knowledge of the participant’s termination of employment, reduction of hours, retirement, or death. However, you or your covered dependent must call Team Member Care (formerly known as the HR Service Center) at 1-877-HRWELLS (1-877-479-3557), option 2, when one of the following events occurs:

- A divorce, legal separation, or termination of domestic partnership or civil union. Notice must be provided to Team Member Care (formerly known as the HR Service Center) within 60 days of the divorce, legal separation, or termination of domestic partnership or civil union.

  In the event of divorce, notify Team Member Care (formerly known as the HR Service Center) of this event separately from any qualified domestic relations order (QDRO) that you may submit for retirement plans.

- A child loses dependent status. Notice must be provided to Team Member Care (formerly known as the HR Service Center) within 60 days of the date the dependent child no longer meets the dependent child eligibility requirements.

Note: Team Member Care (formerly known as the HR Service Center) 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 birthdate). The child will be deemed ineligible at the end of the month in which the child turns age 26 regardless of any separate notification requirements for which you are responsible.

When Team Member Care (formerly known as the HR Service Center) is notified that one of these events has occurred and you have confirmed the mailing address of the qualified beneficiary, the COBRA administrator will notify the appropriate parties of their COBRA continuation coverage rights. Note: A notice to your spouse or domestic partner is treated as notice to any covered dependents who reside with the spouse or domestic partner.

If you wait longer than 60 days after the date your dependent no longer meets the dependent eligibility requirements to notify Team Member Care (formerly known as the HR Service Center) of the qualifying event, he or she may lose all COBRA continuation rights.
Length of COBRA continuation coverage

The maximum length of COBRA continuation coverage for qualified beneficiaries under each qualifying event is as follows:

<table>
<thead>
<tr>
<th>Qualifying event</th>
<th>Maximum extension and cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment classification changes from regular or part-time to flexible.</td>
<td>18 months, full cost&lt;sup&gt;1,2,3,4,5,7&lt;/sup&gt;</td>
</tr>
<tr>
<td>A dependent child reaches the age limit.</td>
<td>36 months, full cost&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>You become legally separated, divorced, or your domestic partnership or civil union is terminated (coverage extends to former spouse, domestic partner, stepchildren, and children of domestic partner).&lt;sup&gt;5&lt;/sup&gt;</td>
<td>36 months, full cost&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>You die (coverage extends to eligible spouse, domestic partner, dependent children, or children of domestic partner).</td>
<td>36 months: 12 months paid by Wells Fargo, 24 months at full cost&lt;sup&gt;4,5,8&lt;/sup&gt;</td>
</tr>
<tr>
<td>You terminate employment (including retirement).</td>
<td>18 months, full cost&lt;sup&gt;1,2,3,4,5,7&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

1. Full cost is the total contribution due, including what was previously paid by you and Wells Fargo, and an additional 2%.
2. If you or your dependent is disabled within the first 18 months of COBRA continuation coverage, the maximum extension will be 11 months (for a total of 29 months of COBRA continuation coverage) if you have provided the proper notice. Refer to the “Social Security disability extension” section on page E-8 for more information. Note: For COBRA participants whose COBRA coverage begins January 1, 2016, or later, the rates paid for COBRA coverage during the extension period are equal to 150% of the premium.
3. If you have a subsequent qualifying event after an initial qualifying event, you may be able to continue COBRA for an extended period of time (not to exceed a total of 36 months of COBRA continuation coverage).
4. Coverage may terminate before the end of the maximum extension as described in the “End of COBRA continuation coverage” section on page E-13.
5. Participation in the Full-Purpose Health Care FSA or Limited Dental/Vision FSA can continue until your COBRA eligibility ends or the end of the current plan year, whichever is earlier.
6. If the legal separation, divorce, or termination of the domestic partnership or civil union occurs within one year after an annual enrollment period during which the spouse or domestic partner is dropped from coverage, the spouse or domestic partner may be eligible for COBRA continuation coverage if the termination of coverage was “in anticipation of” the legal separation, divorce, or termination of the domestic partnership. Once notified of legal separation, divorce, or termination of the domestic partnership or civil union (in accordance with the procedures outlined in the “Your notification responsibilities — primary qualifying events” section on page E-6), the plan administrator (or its designee) will determine whether the previous termination of coverage was “in anticipation of” the legal separation, divorce, or termination of the domestic partnership in accordance with the plan’s internal policies and procedures. If the ex-spouse or former domestic partner is eligible for and elects COBRA continuation coverage, COBRA continuation coverage will begin on the first of the month following the date of legal separation, divorce, or termination of domestic partnership.
7. When the qualifying event is the end of your employment or reduction of your hours of employment, and you become eligible for Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 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.
8. In the event of a team member’s death, the first 12 months of COBRA continuation coverage for medical, dental, and vision benefit options (for the covered eligible dependent) under the Wells Fargo & Company Health Plan will be paid in full by Wells Fargo. Wells Fargo does not make any contributions to a flexible spending account, even during the first 12 months of COBRA.

The “Length of COBRA continuation coverage” table above shows the maximum period of COBRA continuation coverage available to qualified beneficiaries. The length of extended coverage under COBRA depends upon the qualifying event triggering eligibility, as illustrated in the table. COBRA continuation coverage will be terminated before the end of the maximum period as described in the “End of COBRA continuation coverage” section on page E-13.
Extending COBRA continuation coverage

If you or your dependent elects COBRA continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You or your dependent must notify BenefitConnect™ | COBRA of a Social Security disability determination or second qualifying event to extend the period of COBRA continuation coverage. Call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers only]. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of COBRA continuation coverage.

Social Security disability extension

An 11-month extension of coverage may be available if a qualified beneficiary* meets both of the following criteria:

• The qualified beneficiary is determined to be disabled by the Social Security Administration at some time before the 60th day of COBRA continuation coverage

• The qualified beneficiary notifies BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers only] of the Social Security Administration’s disability determination and provides a copy of the Social Security disability award letter to BenefitConnect™ | COBRA before the end of the initial 18-month COBRA continuation period and within 60 days of the later of:

  – The date on which the qualifying event — termination of employment or reduction of hours — occurs
  – The date coverage is lost (or would be lost) as a result of the qualifying event
  – The date of the disability determination by the Social Security Administration
  – The date that the qualified beneficiary receives the initial COBRA notice or a Benefits Book that describes the notice procedures (or is deemed to receive the initial COBRA notice or Benefits Book)

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
  PO Box 5884
  Hopkins, MN 55343

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. For COBRA participants whose COBRA coverage begins January 1, 2016, or later, 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 (26272) [or (858) 314-5108 for International callers only] within 60 days of the Social Security Administration’s determination.

• If the qualified beneficiary is determined to no longer be disabled within the original COBRA extension period, he or she 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, his or her COBRA continuation coverage will be terminated at the end of the month in which BenefitConnect™ | COBRA is notified that the individual is no longer disabled.

Secondary qualifying event

An 18-month extension of coverage may be available to your spouse or domestic partner and dependent children who elect COBRA continuation coverage if a second qualifying event occurs during their first 18 months of COBRA continuation coverage. The maximum amount of COBRA continuation coverage available when a second qualifying event occurs is 36 months. These second qualifying events include:

• Your divorce or legal separation, or termination of a domestic partnership or civil union.

• Your death.

• Your dependent child ceases to be eligible for coverage under the terms of the group health plan.

* For purposes of the disability extension, a qualified beneficiary is a participant and his or her dependent children, spouse, or domestic partner, who lost medical, dental, or vision coverage due to the participant’s termination of employment or reduction in hours. A child who is born to or placed for adoption with a covered participant during a period of COBRA continuation coverage is also a qualified beneficiary.
## Extension of Coverage

<table>
<thead>
<tr>
<th>Secondary qualifying event</th>
<th>Maximum extension for covered spouse, domestic partner, or dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>You become legally separated or divorced or terminate a domestic partnership or civil union, after the initial qualifying event.</td>
<td>Additional 18 months for a maximum of 36 months</td>
</tr>
<tr>
<td>You die.</td>
<td>Additional 18 months for a maximum of 36 months</td>
</tr>
<tr>
<td>Your dependent child loses dependent status because your child is no longer under age 26.</td>
<td>Additional 18 months for a maximum of 36 months available for the dependent child who loses coverage</td>
</tr>
</tbody>
</table>

These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the group health plan if the first qualifying event had not occurred.

To receive this additional 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 (26272) [or (858) 314-5108 for International callers 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.

Note: BenefitConnect™ | COBRA will know when a dependent child becomes ineligible due to turning age 26 (based on the child’s birthdate) and COBRA continuation coverage ends at the end of the month in which he or she turns 26. As a result of this second qualifying event, the applicable COBRA information will be sent to the child at the address of record, allowing him or her to make an independent COBRA election.

### 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 (26272) [or (858) 314-5108 for International callers 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

You and your covered dependents 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

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.
Benefits confirmation statement and corrections

The primary account holder for the COBRA continuation coverage will receive a letter confirming your COBRA enrollment after COBRA enrollment elections have been made, either after initial enrollment under COBRA or during Annual Benefits Enrollment. You may also confirm your COBRA enrollment elections online at https://cobra.ehr.com. If the enrollment information does not match the elections made, call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers 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 team member contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage, 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. Within two weeks after you enroll in COBRA coverage, you will receive a packet of COBRA payment coupons, with a coupon for each monthly payment due in the current plan year, that should be used to submit payments. However, after your first payment has been made, you may choose to pay for COBRA continuation coverage through one of the following options:

• 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 (26272) [or (858) 314-5108 for International callers 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 elect COBRA continuation coverage. However, notification of enrollment in COBRA continuation coverage will be sent to the applicable claims administrator only after the first payment is received and processed, if the payment was timely received. You must make your first payment for COBRA continuation coverage by 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.

Payment 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 (26272) [or (858) 314-5108 for International callers 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 the address noted on the next page.
• 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 (26272) [or (858) 314-5108 for International callers 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

Failure to submit the required COBRA payment by one of the methods listed above may result in a delay in payment processing and possible cancellation of your COBRA continuation coverage for nonpayment.

• Do not include any additional correspondence with your payment.

Monthly payments of COBRA continuation coverage

After you make your first COBRA payment, payments are due for each subsequent month by the first of the month for which you want coverage. The amount due for each month for each enrolled qualified beneficiary is shown on the applicable monthly COBRA payment coupon. You should have received a packet of COBRA payment coupons, with a coupon for each monthly payment due in the current plan year, within two weeks following the date you elect COBRA continuation coverage. If you have not received the packet of COBRA payment coupons within this time period, call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers 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 (26272) [or (858) 314-5108 for International callers 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 regular U.S. mail and postmarked by the due date as indicated on the applicable monthly COBRA payment coupon. If you do not have a COBRA payment coupon, mail your payment along with your unique Customer ID found on your COBRA Election Notice. Alternatively, you can send your monthly payment with the COBRA payment coupon or unique Customer ID by overnight delivery to the following address:

  Wells Fargo  
  Lockbox Services 205896  
  2975 Regent Blvd  
  Irving, TX 75063

All COBRA payments are due by the first of the month for which you want coverage.

If your COBRA payment is late, you have a 30-day grace period to make full payment as described in the “Grace periods for monthly payments” section starting on page E-12. This grace period does not apply to the first payment due.

Payments 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 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 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 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.

If your required monthly payment is not 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 postmarked by January 1. However, if the payment is missed or delayed, the delinquent payment must be postmarked on or before January 31 to be considered timely made for the January coverage. If the payment is postmarked February 1 or after, it will not be applied to your continuation coverage and COBRA continuation coverage will end as of December 31.*

* Please note that all payments received will be deposited before a determination is made as to whether any such payment is timely made. Late payments will be refunded to you and will not extend your COBRA continuation coverage. Depositing of payments should not be construed as acceptance of payment in full.

Please remember that you should send the COBRA payment with the applicable monthly COBRA payment coupon. However, if you do not have the applicable monthly COBRA payment coupon, submit your payment with your unique Customer ID (found on your original COBRA Election Notice) to the address noted below. All payments for COBRA continuation coverage should be sent by U.S. mail to:

Wells Fargo
PO Box 205896
Dallas, TX 75220-5896

Or you can send payment by overnight delivery to:
Wells Fargo
Lockbox Services 205896
2975 Regent Blvd
Irving, TX 75063

Changing COBRA continuation coverage
Whenever your status or that of a dependent changes, you must notify BenefitConnect™ | COBRA of the change within 60 days. COBRA continuation coverage may be modified based on plan rules if you experience a Qualified Event (for example, birth, marriage, legal separation, divorce, termination of a domestic partnership, or change in dependent eligibility). Refer to “Chapter 1: An Introduction to Your Benefits” in this Benefits Book for a complete list of Qualified Events. Premiums may be adjusted for coverage changes.

Adding a dependent to COBRA continuation coverage
Although you may add eligible dependents if you experience a Qualified Event, these dependents will generally not be qualified beneficiaries. If you experience a Qualified Event and wish to add a dependent to your COBRA continuation coverage, you must notify BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers 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 (26272) [or (858) 314-5108 for International callers 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 his or her 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 (26272) [or (858) 314-5108 for International callers 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.

Note: See the “Secondary qualifying event” section on page E-8 if any of the following events occur:

- Legal separation, divorce, or termination of a domestic partnership or civil union, if you cover your spouse or domestic partner.
- Your death.

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 (26272) [or (858) 314-5108 for International callers 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: An Introduction to Your Benefits” in this Benefits Book.

End of COBRA continuation coverage

If you or your dependents choose COBRA continuation coverage, it may be continued for the period of time indicated in the “Length of COBRA continuation coverage” table on page E-7. Whenever your status or that of a dependent changes, you must notify BenefitConnect™ | COBRA of the change within 60 days. (See the “Changing COBRA continuation coverage” section on page E-12 and the “Secondary qualifying event” section on page E-8 for more information.)

However, coverage will end before the maximum extension date if any of the following situations occur:

- Any required premium or contribution is not paid in full. Coverage will be terminated retroactively to the end of the month for which full payment was made.
- COBRA payments are not postmarked as of the due date and exceed the 30-day grace period. Coverage will be terminated retroactively to the end of the month for which full payment was made.
- Wells Fargo no longer provides medical, dental, vision, Full-Purpose Health Care FSA, or Limited Dental/Vision FSA coverage to any of its team members. Coverage will terminate on the date the applicable coverage is no longer offered.
You or your dependent obtains coverage under another group plan after your COBRA qualifying event. Coverage will be terminated effective the first of the month following the date the individual obtained coverage under the other group plan or the date you notify BenefitConnect™ | COBRA, whichever is later.

For any reason the plan would terminate coverage of a non-COBRA participant (such as fraud).

Premiums or contributions will continue to be accepted and processed until you notify and provide any required documentation to BenefitConnect™ | COBRA. Claims incurred by you or a dependent after the end of the month in which coverage ends will be denied. If claims were paid for expenses incurred after the termination date, you will be required to repay the plan.

For more information

If you need additional information, access https://cobra.ehr.com or call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers only]. Representatives are available from Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time.

For more information about health insurance options available through a Health Insurance Marketplace, visit healthcare.gov.

Keep your plan informed of address changes

To protect your and your family’s rights, you should keep BenefitConnect™ | COBRA informed of any changes in your address and the addresses of family members by calling 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers only] or online at https://cobra.ehr.com. You should also keep a copy for your records of any correspondence with BenefitConnect™ | COBRA.

Plan contact information

For more information about COBRA continuation coverage and the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents), the Wells Fargo & Company Health Care Flexible Spending Account Plan, and the Wells Fargo & Company International Plan:

• Visit https://cobra.ehr.com

• Call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) [or (858) 314-5108 for International callers only]

• Send a written request to
  BenefitConnect | COBRA
  PO Box 5884
  Hopkins, MN 55343-5884

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.