
Important extensions to benefit plan deadlines for certain retiree benefit plans

Please take the time to read this supplementary information that applies to the Wells Fargo & Company Retiree Plan (Retiree Plan) and the Wells Fargo & Company Retiree Life Insurance Plan (Retiree Life Insurance Plan) to determine if these changes are applicable to you. Keep a copy of it with the 2021 *Retiree Benefits Book* or other applicable Retiree Plan Summary Plan Description (SPD).

Important extensions to benefits plan deadlines

In response to the COVID-19 outbreak, the Department of Labor and the Department of Treasury issued a rule in 2020 extending certain deadlines for group health and other welfare benefit plans. As a result, certain deadlines stated in the *Retiree Benefits Book* (or other applicable retiree SPD) for electing and paying for COBRA continuation coverage and filing claims and appeals have been extended during the “Outbreak Period” related to COVID-19.

What is being extended?

The deadlines for electing and paying for COBRA continuation coverage and for filing claims and appeals have been extended. When calculating the new deadlines, plans must disregard the period from March 1, 2020, until sixty (60) days after the announced end of the Presidentially declared National Emergency or other date announced later (the “Outbreak Period”), subject to an overall maximum period of one year. This extension is intended to provide relief for plan participants and beneficiaries during the National Emergency.

Who does this affect?

All retirees and their covered dependents who are participants in the Retiree Plan and the Retiree Life Insurance Plan, and COBRA participants under the Retiree Plan should be aware of these changes. If you are trying to determine a deadline that occurs within the Outbreak Period, you may be affected by this regulatory update and may have additional time to take action. You should contact the relevant party listed in the “Questions” section at the end of this document for more information. Keep in mind that the examples provided are for illustrative purposes only and do not capture all nuances of the deadline extensions. If you experienced one of these events before March 1, 2020, a prorated deadline extension may apply.

COBRA continuation coverage extensions

Plans affected

Medical, dental, and vision coverage under the Retiree Plan:

- UnitedHealthcare pre-Medicare self-insured options: HRA-Based Medical Plan and HSA-Based Medical Plan
- Kaiser fully-insured pre-Medicare options: HMO Kaiser (Northern and Southern California) and POS Kaiser Added Choice – Hawaii
- UnitedHealthcare Group Medicare Advantage Plan
- UnitedHealthcare Temporary Medicare Supplement Plan
- Kaiser Medicare Advantage plans (Northern and Southern California)
- Retirement Medical Allowance Account (RMAA)
- Prudential Securities Inc. Retirement Medical Allowance (PSI RMA)
- Retiree Dental Plan
- Retiree Vision Plan

Extension of COBRA election period

- **What is it?** COBRA requires that the Wells Fargo group health plans give covered retirees and their covered dependents 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 election period for COBRA normally runs from the later of the following time frames: 60 days from the date of the COBRA Election Notice, or 60 days from the date coverage terminates. For more information, see “Appendix E: Continuing Coverage Under COBRA” in the *Retiree Benefits Book* or the COBRA information in the individual SPDs for the Retiree Vision Plan and PSI RMA Plan.
- **How is the deadline extended?** Our COBRA administrator is allowing COBRA elections to be made until 60 days after the end of the Outbreak Period.
- **Illustrative example for COBRA election period:** Mark was provided his COBRA Election Notice on April 1, 2020, after the Outbreak Period started. He would normally have 60 days from April 1 to enroll in COBRA. Now, the last day of his COBRA election period is 60 days after the end of the Outbreak Period.

Extension of COBRA premium payment deadlines

- **What is it?** COBRA requires that initial premium payments be made within 45 days after the date a COBRA continuation coverage election is made. After the first payment is made, there is a 30-day grace period to make payments for subsequent months. For more information, see “Appendix E: Continuing Coverage Under COBRA” in the *Retiree Benefits Book* or the COBRA information in the individual SPDs for the Retiree Vision Plan and PSI RMA.
- **How is the deadline extended?** Our COBRA administrator is allowing 60 days after the Outbreak Period to make these payments.
- **Illustrative example for COBRA payments:** On October 1, 2020, Naomi was already enrolled in COBRA continuation coverage under the Retiree Plan. Her monthly premium payments are due by the first of the month, but there is a 30-day grace period for making monthly premium payments. She made a timely October payment, but did not make the November or December payments. Now, the premium payments for both November and December will be due 60 days after the end of the Outbreak Period.
- **Important notes:**
 - Once you elect COBRA continuation coverage and make your first premium payment, your coverage will be reinstated retroactive to the date your coverage terminated due to your qualifying event.
 - If you defer making your COBRA premium payments, you could have a large bill due 60 days after the end of the Outbreak Period. To avoid needing to make a large lump sum payment, you can choose to continue to pay your monthly premiums when they would normally be due. We reserve the right to pend COBRA coverage for nonpayment. If this happens, the COBRA administrator will retroactively reinstate coverage when payment is received.

- Upon the end of the Outbreak Period, normal payment deadlines will resume and you will be responsible for all COBRA premiums unpaid during the Outbreak Period. If payments are not made by the new deadline, coverage will be terminated retroactive to the last month paid in full and you will be responsible for claims incurred during this period for which premiums were not paid.

Extensions for filing claims and appeals

Plans affected

The Life Insurance Plan and certain medical, dental, and vision coverage under the Retiree Plan listed below:

- UnitedHealthcare pre-Medicare self-insured options: HRA-Based Medical Plan and HSA-Based Medical Plan
- Kaiser fully-insured pre-Medicare options: HMO Kaiser (Northern and Southern California) and POS Kaiser Added Choice – Hawaii
- UnitedHealthcare Temporary Medicare Supplement Plan
- Retirement Medical Allowance Account (RMAA)
- Prudential Securities Inc. Retirement Medical Allowance (PSI RMA)
- Retiree Dental Plan
- Retiree Vision Plan

Note: If you are enrolled in a fully-insured Kaiser Medicare Advantage medical option or in the fully-insured UnitedHealthcare Group Medicare Advantage medical option under the Retiree Plan, refer to the Evidence of Coverage or similar documentation provided directly from or made available to you by your carrier instead of this communication for applicable claims and appeals procedures. Contact information is provided at the end of this communication.

Extension of timeframe for filing benefit claims under the claims procedures

- **What is it?** Employee benefit plans that are subject to the Employee Retirement Income Security Act of 1974 as amended (ERISA) must establish and maintain procedures for the filing and initial disposition of benefit claims. The claims procedures are stated in the applicable chapter of the *Retiree Benefits Book* or in the applicable section of the individual SPDs for the Retiree Vision Plan, PSI RMA, or UnitedHealthcare Medicare Supplement Plan.
- **How is the deadline extended?** Timeframes for submitting claims vary by plan. The Outbreak Period is disregarded in determining when claims must be submitted.
- **Illustrative example for filing a claim for medical treatment:** Vanessa is enrolled in a pre-Medicare retiree medical plan. On March 1, 2020, she received treatment for a medical condition under the plan, but a claim was not submitted until April 1, 2021. Under the plan, claims normally must be submitted within 365 days of the receipt of treatment, and, as a result, an April 1, 2021, submission would be too late. Under the new rules, submitting the claim on April 1, 2021, would be timely if we assume, for sake of the example, the Outbreak Period ended January 29, 2021.

Extension of timeframe for appealing an adverse benefit determination

- **What is it?** ERISA-covered employee benefit plans must establish and maintain procedures governing benefit claims, including providing claimants with a reasonable opportunity to appeal adverse benefit determinations to an appropriate named fiduciary. The timeframes for filing claim appeals for the medical, dental, and RMAA claims are stated in “Appendix A: Claims and Appeals” in the *Retiree Benefits Book*. The timeframes for filing claim appeals under the Retiree Vision Plan or PSI RMA are stated in the applicable section of the separate SPDs for those plans.
- **How is the deadline extended?** Timeframes for filing appeals vary by plan. In calculating the deadline, the Outbreak Period is disregarded.
- **Illustrative example for appealing an adverse benefit determination:** Maria received a notification of an adverse benefit determination under the pre-Medicare medical plan on March 10, 2020. The notification advised Maria that she has 180 days to file an appeal. When determining the appeal deadline, the Outbreak Period is disregarded. Therefore, the 180-day clock would start to run after the end of the Outbreak Period.

Questions

For questions about your medical coverage, or outstanding medical claims or appeals, contact your insurance claims administrator. See listing below or refer to your plan ID card.

Pre-Medicare Plans

- UnitedHealthcare: 1-800-842-9722
- Express Scripts (pharmacy): 1-855-388-0352
- Kaiser California (Northern and Southern): 1-800-464-4000
- POS Kaiser Added Choice – Hawaii: 1-800-966-5955

Medicare Plans

- UnitedHealthcare Medicare Advantage: 1-800-430-5471
- UnitedHealthcare Temporary Medicare Supplement Plan: 1-800-842-9722
- Kaiser Medicare Advantage: 1-800-443-0815

Retirement Medical Allowance Accounts (RMAA and PSI RMA)

- HealthEquity: 1-877-924-3967

Retiree Dental Plan

- Delta Dental of Minnesota – Minneapolis and St. Paul metro area: 651-994-5342
- Delta Dental of Minnesota – all other areas: 1-877-598-5342

Retiree Vision Plan

- Vision Service Plan (VSP): 1-877-861-8352

Retiree Life Insurance Plan

- Metropolitan Life Insurance Company (“MetLife”): 1-866-549-2320

COBRA

For questions about your COBRA continuation coverage rights contact the COBRA Administrator: BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). Representatives are available from Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time. You may also access <https://cobra.ehr.com>.

The information presented in this communication does not provide all of the terms and provisions of the retiree benefits sponsored by Wells Fargo & Company. The benefit plans are maintained pursuant to and governed by official plan documents, which may consist of plan documents, summary plan descriptions, insurance policies, and certificates of coverage (collectively, the “plan documents”). In the case of a discrepancy between the information presented herein and the official plan documents, the official plan documents will control. If there are any errors or omissions in such materials, Wells Fargo & Company, the plan administrator, or their authorized designees reserve the right to correct such errors or omissions. For a more detailed summary of the retiree benefit plans, see the applicable summary plan description and certificates of coverage (for fully insured options).

Wells Fargo & Company reserves the unilateral right to amend, modify, or terminate any of its benefits 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.

COVID-19 testing and evaluation

Wells Fargo & Company Retiree Plan

Please take the time to read this supplementary information to the Wells Fargo & Company Retiree Plan (Retiree Plan) describing how testing and evaluation for COVID-19 is covered effective January 1, 2021, and keep a copy of it with your 2021 *Retiree Benefits Book* or other applicable Retiree Plan SPD.

Testing and evaluation coverage for COVID-19

The Families First Coronavirus Response Act passed in 2020 dictates how testing and evaluation services for COVID-19 are covered under the following medical options of the Retiree Plan:

Pre-Medicare plans

- HRA-Based Medical Plan
- HSA-Based Medical Plan
- Kaiser HMO – California
- POS Kaiser Added Choice – Hawaii

Medicare plans

- UnitedHealthcare Group Medicare Advantage Plan
- Kaiser Medicare Advantage plans
- UnitedHealthcare Temporary Medicare Supplement Plan

Under The Families First Coronavirus Response Act, while the federally-declared public health emergency related to COVID-19 is in effect, there is no cost sharing for (meaning, you will not pay for) deductibles, copayments, and coinsurance for items and services provided to a covered individual during a health care provider office visit (both in person and telehealth), urgent care and emergency room that results in an order for or administration of a test for COVID-19. The items and services must be medically necessary and relate to the furnishing or administration of the COVID-19 test or the evaluation of the individual to determine if the COVID-19 test is needed.

However, if a covered individual is diagnosed with COVID-19, all treatment including but not limited to hospital, transportation, and pharmacy services will be subject to deductibles, coinsurance, and copays in accordance with the terms of the applicable plan. Upon the expiration of the federally-declared public health emergency related to COVID-19 under Section 319 of the Public Health Service Act, all services related to COVID-19 testing will no longer be required to be provided without cost sharing and may be subject to deductibles, coinsurance, and copays in accordance with the terms of the applicable plan.

- HRA-Based Medical Plan and HSA-Based Medical Plan terms are stated in the *Retiree Benefits Book*.
- Kaiser HMO (Northern and Southern California) or POS Kaiser Added Choice – Hawaii plan terms are stated in your certificate of coverage or other documentation made available to you by Kaiser at <https://my.kp.org/wf>.
- UnitedHealthcare Group Medicare Advantage Plan terms are stated in the documentation made available to you by UnitedHealthcare at UHCRetiree.com/wf.
- Kaiser Medicare Advantage plans terms are stated in the documentation made available to you by Kaiser at kp.org.
- The UnitedHealthcare Temporary Medicare Supplement Plan terms are stated in the separate Summary Plan Description sent to you if you are enrolled in that medical option.

Questions

Please contact your health insurance claims administrator noted below for more information about your medical coverage, or for assistance with navigating their websites. You may also refer to the information on the back of your plan ID card for contact information.

Pre-Medicare Plans

- UnitedHealthcare: 1-800-842-9722 or myuhc.com
- Kaiser HMO (Northern and Southern California): 1-800-464-4000 or <https://my.kp.org/wf>
- POS Kaiser Added Choice – Hawaii: 1-800-966-5955 or <https://my.kp.org/wf>

Medicare Plans

- United Healthcare Medicare Advantage: 1-800-430-5471 or UHCRetiree.com/wf
- Kaiser Medicare Advantage: 1-800-443-0815 or kp.org
- UnitedHealthcare Temporary Medicare Supplement Plan: 1-800-842-9722 or myuhc.com

The information presented in this communication does not provide all of the terms and provisions of the Wells Fargo & Company Retiree Plan. The Retiree Plan is maintained pursuant to and governed by official plan documents, which may consist of plan documents, summary plan descriptions, insurance policies, and certificates of coverage (collectively, the “plan documents”). In the case of a discrepancy between the information presented herein and the official plan documents, the official plan documents will control. If there are any errors or omissions in such materials, Wells Fargo & Company, the plan administrator, or their authorized designees reserve the right to correct such errors or omissions. For a more detailed summary of the retiree benefit plans, see the applicable summary plan description and certificates of coverage (for fully insured options).

Wells Fargo & Company reserves the unilateral right to amend, modify, or terminate any of its benefits 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.



Retiree COVID-19 vaccine coverage

Please read this Summary of Material Modifications to the Wells Fargo & Company Retiree Plan (Retiree Plan) describing how the COVID-19 vaccine is covered and keep a copy of it with your *Retiree Benefits Book*. It's important to note that the Retiree Plan is not responsible for vaccine availability; availability depends on your community's plan for obtaining and distributing the vaccine.

COVID-19 vaccine coverage

The Coronavirus Aid, Relief, and Economic Security (CARES) Act passed in 2020 dictates how the COVID-19 vaccine is covered under the following medical options of the Retiree Plan (collectively, the "Plan"):

Pre-Medicare plans

- HRA-Based Medical Plan
- HSA-Based Medical Plan
- Kaiser HMO - California
- POS Kaiser Added Choice – Hawaii

Medicare plans

- UnitedHealthcare Group Medicare Advantage Plan
- Kaiser Medicare Advantage plans
- UnitedHealthcare Temporary Medicare Supplement Plan

In accordance with the CARES Act, the COVID vaccine is considered a "recommended preventive service" as defined by the Affordable Care Act. This means that the costs associated with the administration of the COVID-19 vaccine (for example, the cost of the vaccine, if any, and the cost of any services integral to the administration of that vaccine) are covered by the Plan without cost share on the same basis as other "routine vaccines." (Review your plan's terms for more information; see the "Review your medical plan option's other coverage and cost-sharing provisions" section on the back of this memo.) Unlike other routine vaccines, the COVID-19 vaccine and integral services are covered without cost share when provided by an out-of-network provider through the end of the Public Health Emergency (as determined by the Secretary of Health and Human

Services). If the vaccine is administered by an out-of-network provider, you may be responsible for any amounts above the Plan's allowed amount for such services. **Note:** Vaccines typically have to be recommended for routine use in order to be covered without cost share; however, that rule does not apply to the COVID-19 vaccine through the end of the Public Health Emergency.

Review your medical plan option's other coverage and cost-sharing provisions

- HRA-Based Medical Plan and HSA-Based Medical Plan terms are stated in the *Retiree Benefits Book*.
- Kaiser HMO (Northern and Southern California) or POS Kaiser Added Choice – Hawaii plan terms are stated in your certificate of coverage or other documentation made available to you by Kaiser at <https://my.kp.org/wf/>.
- UnitedHealthcare Group Medicare Advantage Plan terms are stated in the documentation made available to you by UnitedHealthcare at UHCRetiree.com/wf.
- Kaiser Medicare Advantage plans terms are stated in the documentation made available to you by Kaiser at [kp.org](https://my.kp.org/wf/).
- The UnitedHealthcare Temporary Medicare Supplement Plan terms are stated in the separate Summary Plan Description sent to you if you are enrolled in that medical option.

Questions

If you have questions about your medical coverage, contact your medical claims administrator. Contact information is on your medical plan ID card.

The information presented in this communication does not provide all of the terms and provisions of the Wells Fargo & Company Health Plan. The Health Plan is maintained pursuant to and governed by official plan documents, which may consist of plan documents, summary plan descriptions, insurance policies, and certificates of coverage (collectively, the "plan documents"). In the case of a discrepancy between the information presented herein and the official plan documents, the official plan documents will control. If there are any errors or omissions in such materials, Wells Fargo & Company, the plan administrator, or their authorized designees reserve the right to correct such errors or omissions. For a more detailed summary of the employee benefit plans, see the applicable summary plan description and certificates of coverage (for fully insured options).

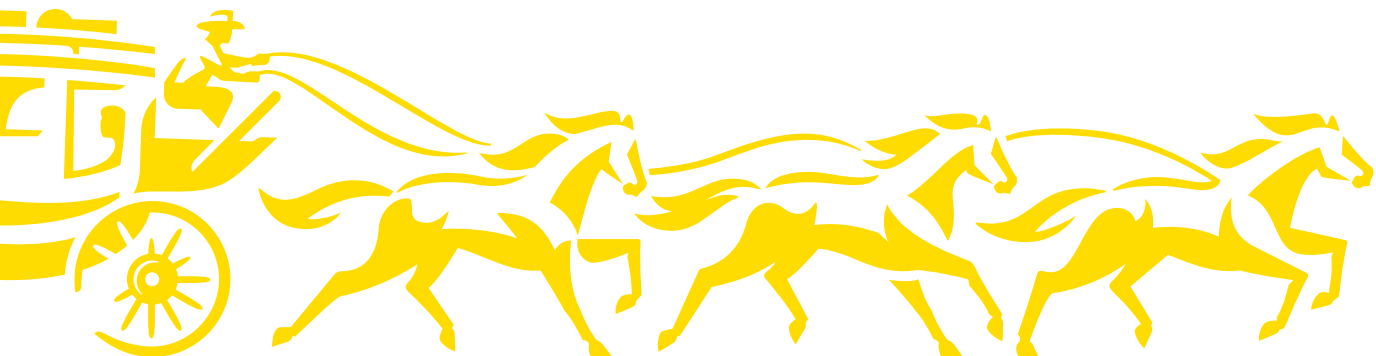
Wells Fargo & Company reserves the unilateral right to amend, modify, or terminate any of its benefit plans, programs, policies, or practices at any time, for any reason, with or without notice. Any such amendment, modification, or termination may apply to both current and future participants, covered spouses or domestic partners, covered dependents, and beneficiaries. Eligibility for, or participation in, the plans does not constitute a guarantee or contract of employment with Wells Fargo.



A guide to your Wells Fargo benefits

Retiree Benefits Book

Effective January 1, 2021



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Chapter 1: Eligibility, Enrollment, and More

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Contacts

Information about retiree medical and dental plans in your area and in-network providers	<p>For plans in your area:</p> <p>The Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1 benefitconnect.wf.ehr.com/ess</p> <p>To identify in-network providers:</p> <p>benefitconnect.wf.ehr.com/ess or call the applicable claims administrator or insurer directly</p>
Information about the Plan	<p>See the “ERISA plans sponsored by Wells Fargo” table at the end of “Appendix B: Important Notifications and Disclosures” in this <i>Retiree Benefits Book</i> for your plan’s member services phone number or website. Also see the Summary Plan Description (SPD) and summary of benefits for your plan</p>
Information about retiree enrollment, eligibility, making coverage changes, retiree medical and dental coverage, rates, or forms	<p>The Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1 benefitconnect.wf.ehr.com/ess</p>
Information about COBRA enrollment	<p>BenefitConnect™ COBRA 1-877-29-COBRA (1-877-292-6272) [(858) 314-5108 International callers only] https://cobra.ehr.com</p>

The basics

Summary Plan Descriptions

This *Retiree Benefits Book* contains Summary Plan Descriptions (SPDs) for certain benefit plans that Wells Fargo sponsors to provide certain benefits to eligible retirees and eligible dependents (collectively, “eligible persons”). Eligibility for these plans begins on page 1-5. SPDs are provided to you at no cost.

An SPD describes various provisions of the applicable benefit plan, such as eligibility and enrollment, how the plans work, when you can make changes, your rights and obligations under the plans, and other important information. This *Retiree Benefits Book* provides the SPDs for the Wells Fargo & Company Retiree Plan (Retiree Plan), which provides a number of medical plan options and a dental coverage option, and the Wells Fargo & Company Retiree Life Insurance Plan (Retiree Life Insurance Plan). The *Retiree Benefits Book* is also accessible electronically at teamworks.wellsfargo.com or at benefitconnect.wf.ehr.com/ess. Every attempt has been made to make the *Retiree Benefits Book* and SPDs easy to understand, informative, and as accurate as possible.

Wells Fargo & Company reserves the unilateral right to amend, modify, or terminate the Wells Fargo & Company Retiree Plan, the Wells Fargo & Company Retiree Life Insurance Plan, or any option or component of either plan at any time, for any reason, with or without notice. Any such amendment, modification, or termination may apply to both current and future participants, covered spouses or domestic partners, covered dependents, and beneficiaries.

Additionally, Wells Fargo & Company may from time to time review eligibility-related data for the Plan that may result in modifications to or termination of benefits to individuals enrolled in the Plan.

Your responsibility

Each covered person 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 health care 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 persons or previously eligible dependents who have elected continuation coverage under COBRA, if applicable. Plan benefits depend on continued eligibility and enrollment.
- The name “Wells Fargo,” as used throughout this document, refers to Wells Fargo & Company.

In case of any conflict between the SPDs in this *Retiree Benefits Book* or any other information provided and the official plan document, the official plan document governs. (In some cases, portions of the *Retiree 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. You may also view the document on-site at this location during regular business hours:

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

Funding arrangements for the plans

Most benefit plans and benefit options may be either self-insured or fully insured (refer to the “[ERISA plans sponsored by Wells Fargo](#)” table at the end of “Appendix B: Important Notifications and Disclosures” in this *Retiree Benefits Book* to determine if the benefit option is insured or self-insured).

When benefits are self-insured, 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 Retiree Plan is responsible for paying benefits.

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

Benefit plan options

Wells Fargo sponsors benefit plans providing certain benefits to eligible persons. Eligibility for these plans is described on page 1-5. Some plans may offer more than one type of benefit option. The benefit plans and corresponding benefit options are listed below.

For purposes of this *Retiree Benefits Book*, the term “retiree medical plan option” means group medical coverage offered to eligible persons under the Wells Fargo & Company Retiree Plan. Different retiree medical plan options are available to eligible persons who are not yet eligible for Medicare (typically under age 65) than to certain eligible persons who are also eligible for Medicare (typically age 65 and older unless eligible before age 65 due to disability or end-stage renal disease). In addition, the Retiree Plan includes a dental coverage option that is administered by a third-party administrator. And for certain eligible persons, Wells Fargo sponsors retiree life insurance benefits under the Wells Fargo & Company Retiree Life Insurance Plan.

- Wells Fargo & Company Retiree Plan

For eligible persons who are not yet eligible for Medicare:

- Health Reimbursement Account (HRA)-Based Medical Plan

- Health Savings Account (HSA)-Based Medical Plan*
- HMO — Kaiser (in certain locations)
- POS Kaiser Added Choice — Hawaii (in Hawaii only)
- Delta Dental
- Retirement Medical Allowance Account (RMAA)

* 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](#).”

For eligible persons who are eligible for Medicare:

- Kaiser Medicare Advantage plans (in certain locations)
- Retirement Medical Allowance Account (RMAA)
- UnitedHealthcare Group Medicare Advantage (PPO) Plan
- UnitedHealthcare Temporary Medicare Supplement Plan
- Wells Fargo & Company Retiree Life Insurance Plan

The individual descriptions of plan benefits for most self-insured retiree medical plan options for covered persons who are not yet eligible for Medicare and for the retiree dental plan option are described in this *Retiree Benefits Book*. For each of these plans, the SPD is made up of the respective chapter and the following:

- “[Chapter 1: Eligibility, Enrollment, and More](#)”
- “[Appendix A: Claims and Appeals](#)”
- “[Appendix B: Important Notifications and Disclosures](#)”
- “[Appendix D: Retiree Group Tables](#)”
- “[Appendix E: Continuing Coverage Under COBRA](#)”

The descriptions of plan benefits for the HMO — Kaiser and POS Kaiser Added Choice — Hawaii are provided in separate documentation that will be provided to you by Kaiser (visit <https://my.kp.org/wf> or kp.org/eoc) if you enroll. The following chapters in this *Retiree Benefits Book* are combined with the information provided to you in the applicable HMO — Kaiser or POS Kaiser Added Choice — Hawaii booklet to make up the complete SPD for your retiree medical plan option:

- “[Chapter 1: Eligibility, Enrollment, and More](#)”
- “[Appendix B: Important Notifications and Disclosures](#)”
- “[Appendix D: Retiree Group Tables](#)”
- “[Appendix E: Continuing Coverage Under COBRA](#)”

If the information provided by the insurer or HMO conflicts with the information in the chapters listed above, the information in this book supersedes and is controlling.

The descriptions of plan benefits for Kaiser Medicare Advantage plans are provided in separate documentation that will be sent to you separately if you are eligible and enroll. The description of plan benefits for the UnitedHealthcare Medicare Advantage Plan is provided in documentation that will be provided to you by UnitedHealthcare if you are eligible and enroll. The

following chapters in this *Retiree Benefits Book* are combined with the information provided to you in the applicable Medicare Advantage booklet to make up the complete SPD for your retiree medical plan option:

- “[Chapter 1: Eligibility, Enrollment, and More](#)”
- “[Chapter 3: Medical Plans for Retirees Eligible for Medicare](#)”
- “[Appendix B: Important Notifications and Disclosures](#)”
- “[Appendix D: Retiree Group Tables](#)”
- “[Appendix E: Continuing Coverage Under COBRA](#)”

The RMAA is described in this *Retiree Benefits Book*. The individual [chapter for the RMAA](#) constitutes the SPD along with the following:

- “[Chapter 1: Eligibility, Enrollment, and More](#)”
- “[Appendix A: Claims and Appeals](#)”
- “[Appendix B: Important Notifications and Disclosures](#)”
- “[Appendix E: Continuing Coverage Under COBRA](#)”

The Retiree Life Insurance Plan is described in this *Retiree Benefits Book*. The individual [chapter for the Retiree Life Insurance Plan](#) constitutes the SPD along with the following:

- “[Chapter 1: Eligibility, Enrollment, and More](#)”
 - “[Appendix B: Important Notifications and Disclosures](#)”
- (Note: Only the “Your rights under ERISA,” “Plan information,” “Participating employers,” and the “Future of the plans” sections apply.)

The description of specific eligibility and plan benefits for the UnitedHealthcare Temporary Medicare Supplement Plan under the Retiree Plan is provided in a separate SPD booklet to you by Wells Fargo if you are eligible and enrolled in the UnitedHealthcare Temporary Medicare Supplement Plan. The SPD booklet constitutes the applicable SPD along with the following:

- “[Chapter 1: Eligibility, Enrollment, and More](#)”
- “[Chapter 3: Medical Plans for Retirees Eligible for Medicare](#)”
- “[Appendix B: Important Notifications and Disclosures](#)”
- “[Appendix D: Retiree Group Tables](#)”
- “[Appendix E: Continuing Coverage Under COBRA](#)”

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 *Retiree Benefits Book* are ERISA-covered plans. However, 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 health savings accounts, refer to “[Appendix C: Health Savings Accounts](#).”

Who's eligible — retirees

There are two categories of eligibility under the Plan; eligible persons may meet #1 only, or both #1 and #2:

1. Eligibility to access the retiree benefit options (for example, pay the full cost of the benefit plan options). For more information, see the “Who's eligible — pre-Medicare retirees” section on this page and the “[Who's eligible — Medicare eligible retirees](#)” section on page 1-6.
2. Eligibility for a monthly subsidy to help pay a portion of the cost for the benefit plan options under the Wells Fargo & Company Retiree Plan as described in “[Appendix D: Retiree Group Tables](#)” or “[Chapter 4: Retirement Medical Allowance Account](#).” (This chapter includes a reference to the Prudential Securities, Inc. Retirement Medical Allowance, or PSI RMA, which is another form of subsidy covered in its own Summary Plan Description. Instructions on how to access this Summary Plan Description can be found in the following paragraph.)

In no case can a retiree (or the surviving dependent of a retiree) have more than one Wells Fargo & Company Retiree Plan medical subsidy. Retiree medical subsidies include those that are applied to the cost of coverage under a Wells Fargo & Company retiree medical plan and described in “Appendix D: Retiree Group Tables” as well as subsidies described in “Chapter 4: Retiree Medical Allowance Account” and in the Prudential Securities, Inc. Retirement Medical Allowance (PSI RMA) Summary Plan Description. To receive a copy of the PSI RMA Summary Plan Description, you may call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

Eligibility to access retiree benefit options is determined based on your age and full years of service on your last day of employment. Additionally, you must have also been in a regular (full-time) or part-time position on your last day of employment. **Note:** Your retirement date is the day after your last day of employment.

Most eligible persons are responsible for the full cost of retiree medical coverage. However, as noted above, some participants from legacy organizations may qualify for a monthly subsidy under the Wells Fargo & Company Retiree Plan as described in “Appendix D: Retiree Group Tables” or through a Retirement Medical Allowance as described above. **Note:** Certain subsidy groups have age and service criteria that is applicable in addition to the eligibility to access retiree benefit options described in this chapter.

Legacy Wachovia employees who retired on or before 1/1/2008 (last day of employment on or before 12/31/2007), are not eligible for a subsidy under the Plan. If you had service with another legacy Wells Fargo entity, you may, however, be eligible for a subsidy.

If you retired from Wachovia, are a retiree from Wachovia (or one of the companies acquired by or merged into Wachovia), and were eligible for retiree medical coverage at the time of your retirement, you may have deferred your retiree coverage election by not making an election at the time of your

retirement. If you deferred your election at the time of your retirement and would like find out more about your available options, contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

Eligibility provisions applicable to rehired Retirees can be found on page 1-30 in the “[When coverage ends](#)” section of this chapter.

The following sections describe Plan provisions for pre-Medicare and Medicare-eligible participants. Note that in the event you choose to cover yourself and eligible dependents under the Plan, some eligible dependents may only be eligible for pre-Medicare options while others may only be eligible for Medicare options. In other situations, Plan eligibility ceases when the participant becomes eligible for Medicare or turns 65, whichever comes first.

Who's eligible — pre-Medicare retirees

If you reside in the U.S. or U.S. territories*, you are eligible for pre-Medicare retiree medical and dental coverage if on your last day of employment with a participating employer of Wells Fargo (on the U.S. payroll system) you meet all of the Wells Fargo & Company Retiree Plan pre-Medicare eligibility criteria provided below. If you meet all of the criteria, you are considered an eligible retiree for pre-Medicare retiree medical and dental enrollment (also referred to as an “Eligible Pre-Medicare Retiree”). If you are an Eligible Pre-Medicare Retiree, you must enroll in accordance with the Plan's enrollment procedures to be covered under the Plan. For more information, see the “[How to enroll](#)” section starting on page 1-21.

*Residency within the U.S. is required to enroll and remain enrolled in retiree medical or dental coverage, unless you resided in a U.S. territory and were enrolled in retiree medical or dental coverage prior to January 1, 2020. Residency within the U.S. is not required for retirees who are eligible for and are currently enrolled in or enroll in the Retiree Medical Allowance Account (RMAA) as described in Chapter 4: Retiree Medical Allowance Account or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance.

You will be an Eligible Pre-Medicare Retiree if you meet both of the following requirements:

- On your last day of employment, you were in a regular (full-time) or part-time position
- You satisfy one of the following age and service* requirements on your last day of employment:
 - On or after age 55 with at least 10 full years of service
 - With at least 80 points (based on your age plus full years of service)
 - If you were: (1) in a regular (full-time) or part-time position and on Wachovia's payroll as of December 31, 2009, and your age plus full years of service equaled 50 or greater as of January 1, 2010, and (2) when your employment with Wells Fargo is terminated, you are at least age 50 with 10 or more full years of service, you are eligible to enroll in pre-Medicare retiree medical coverage and retiree dental

* Your years of service are measured from your corporate hire date or adjusted service date, whichever is earlier. Partial years are not considered. **Note:** Certain subsidy groups have age and service criteria that is applicable in addition to the eligibility access described above.

Pre-Medicare dependents of a Medicare-eligible Retiree:

Enrollment in the Wells Fargo & Company Retiree Plan pre-Medicare plan options is not available once eligible for Medicare or as of the first of the month that you reach age 65, whichever comes first. However, if the Medicare-eligible retiree meets the 65 with one full year of service eligibility criteria on your last day of employment, although the retiree is not eligible to enroll in a pre-Medicare plan option, eligible dependents may enroll in a pre-Medicare plan option until the eligible dependents are eligible for Medicare or the first of the month of reaching age 65, whichever comes first. **Note:** For first of the month birthdays, eligibility in the pre-Medicare plan option ends the day before the first day of the previous month.

Who's eligible — Medicare eligible retirees

If you reside in the U.S*, you are eligible for Medicare retiree medical coverage if on your last day of employment with a participating employer of Wells Fargo (on the U.S. payroll system) you meet all of the Wells Fargo & Company Retiree Plan Medicare eligibility criteria provided below. If you meet all of the criteria, you are considered an eligible retiree for Medicare retiree medical enrollment (also referred to as an "Eligible Medicare Retiree"). If you are an Eligible Medicare Retiree, you must enroll in accordance with the Plan's enrollment procedures to be covered under the Plan. For more information, see the "[How to enroll](#)" section starting on page 1-21.

*Residency within the U.S. is required to enroll and remain enrolled in retiree medical or dental coverage, unless you resided in a U.S. territory and were enrolled in retiree medical or dental coverage prior to January 1, 2020. Residency within the U.S. is not required for retirees who are eligible for and are currently enrolled in or enroll in the Retiree Medical Allowance Account (RMAA) as described in Chapter 4: Retiree Medical Allowance Account or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance.

You will be an Eligible Medicare Retiree if you meet all of the following requirements:

- You are enrolled in Medicare Part A and Part B
- On your last day of employment, you were in a regular (full-time) or part-time position
- You satisfy one of the following age and service* requirements on your last day of employment to be considered an Eligible Medicare Retiree:
 - On or after age 55 with at least 10 full years of service
 - With at least 80 points (based on your age plus full years of service)
 - At age 65 with one full year of service

* Your years of service are measured from your corporate hire date or adjusted service date, whichever is earlier. Partial years are not considered.

- You are eligible for a subsidy as described in "[Appendix D: Retiree Group Tables](#)" or "[Chapter 4: Retirement Medical Allowance Account](#)", or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance.

Special rules apply for retirees who are eligible for Medicare due to ESRD as described in the "[Important information about retiree medical coverage for Medicare-eligible individuals](#)" section beginning on page 1-7.

Note: If you or your dependents are Medicare-eligible and not eligible for a subsidy under the Plan once eligible for Medicare, you will receive information about a voluntary Medicare coordinator service, Via Benefits. Via Benefits and the health insurance products and services it recommends are not a part of the Wells Fargo & Company Retiree Plan.

Pre-Medicare dependents of retirees already covered under a Wells Fargo-sponsored Medicare Advantage plan option as of April 1, 2018, who become Medicare eligible after that date, are eligible for Medicare Advantage coverage under the Plan.

Who's not eligible for retiree medical and dental coverage

- If you reach age 65 and are not eligible for Medicare, you are not eligible for medical coverage under the Wells Fargo & Company Retiree Plan.
- If your dependent reaches age 65 and is not eligible for Medicare, he or she is not eligible for medical coverage under the Wells Fargo & Company Retiree Plan.
- If you or your covered dependents are enrolled in coverage under a Wells Fargo & Company Retiree Plan Medicare Advantage option and become incarcerated, the Centers for Medicare & Medicaid Services (CMS) requires that you be disenrolled from the Medicare Advantage plan on the first of the month following your incarceration. You cannot reenroll in coverage under the Wells Fargo & Company Retiree Plan at any time in the future.
- If you or any of your covered dependents do not have a valid Medicare Beneficiary Identifier (MBI) on file with Wells Fargo for purposes of the administration of Medicare Advantage coverage under the Wells Fargo & Company Retiree Plan, you or your covered dependent whose MBI is not on file will not be accepted for enrollment in the Medicare Advantage plan by CMS.
- If you do not have a physical address within the U.S. or U.S. territories on file with Wells Fargo for purposes of the administration of Medicare Advantage coverage under the Retiree Plan, you and your covered dependents will generally not be accepted for enrollment in the Medicare Advantage plan by CMS.
- If you are eligible for and elected a Retirement Medical Allowance Account, you are not eligible to enroll in any other retiree medical coverage option.
- If you drop your coverage or your coverage ends at any time, you cannot reenroll in coverage. (This provision does not apply to rehired retirees, as described in the "[Rehired retirees](#)" section on page 1-31.)
- If you fail to make timely payments, your coverage will be dropped and you cannot reenroll in coverage.

Note: If you are age 65 or older (or you will turn age 65 in the month following your last day of employment), you are not eligible for retiree dental coverage, unless otherwise noted in 01

Important information about retiree medical coverage for Medicare-eligible individuals

This section contains important information about retiree medical coverage once you or your covered dependent is eligible for Medicare. (This section does not apply to Medicare-eligible retirees who are participants in the Retirement Medical Allowance Account (RMAA) or Prudential Securities Inc. Retirement Medical Allowance (PSI RMA)).

Once you or your covered dependent is eligible for Medicare for any reason (except for eligibility due to end-stage renal disease (ESRD)), the Medicare-eligible individual must be enrolled in Medicare Part A and Part B to elect or continue retiree medical coverage under the Wells Fargo & Company Retiree Plan. The Medicare-eligible individual must also elect retiree medical coverage under a Medicare Advantage plan prior to the first of the month in which the Medicare-eligible individual becomes eligible for Medicare. If you or your Medicare-eligible dependent do not elect coverage in a Medicare Advantage plan option prior to the first of the month in which the Medicare-eligible person turns 65, you may experience a gap in coverage. Pre-Medicare coverage options end the day before the first of the month in which the Medicare-eligible person turns 65 or otherwise becomes eligible for Medicare. Medicare coverage options generally begin on the first of the month following the date you elected Medicare Advantage coverage or the first of the month following the date you became eligible for Medicare benefits, whichever is later.

You must call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, immediately to advise of your or your dependent's eligibility for Medicare. You will need to provide your (or your covered dependent's) Medicare Beneficiary Identifier (MBI) and effective date of Medicare coverage.

- Special rules apply if you or your covered dependent is eligible for Medicare before age 65 due to ESRD. See the [“Retiree medical coverage when you or your covered dependent is currently enrolled in a Wells Fargo & Company pre-Medicare medical plan option and become eligible for Medicare before 65”](#) section starting on this page.
- If you or your covered dependent became eligible for Medicare prior to your initial enrollment in retiree medical coverage under the Wells Fargo & Company Retiree Plan, see the remainder of this section for additional details. Enrollment in Medicare Part A and Part B no later than the first of the month following your last day of employment is important to avoid a potential gap in coverage. To ensure timely enrollment in Medicare, you should begin the process several months in advance. More information can be found in the [“Retiree medical coverage when you or your dependent is eligible for Medicare before age 65 on or before the 1st of the month following your last day of employment”](#) section on page 1-8 and the [“Retiree medical coverage when you or your](#)

[dependent is 65 or older on or before the 1st of the month following your last day of employment”](#) section on page 1-9.

If your retiree medical coverage is dropped because you did not enroll in Medicare Part A and Part B as required in this section, coverage for all of your covered dependents will also be dropped.

If your covered dependent does not enroll in Medicare Part A and Part B as required in this section, your covered dependent will be dropped from your retiree medical coverage and cannot be reinstated unless you have a Qualified Event allowing you to add him or her to your retiree medical coverage (see the [“Changing benefit elections”](#) section on page 1-24) and your covered dependent is enrolled in Medicare Part A and Part B at that time.

If you enroll in Medicare Part A and Part B, but drop Medicare Part A or Part B at a later date, you and your covered dependent's medical coverage under the Retiree Plan will be terminated and cannot be reinstated in the future.

If your Medicare-eligible covered dependent enrolls in Medicare Part A and Part B, but drops Medicare Part A or Part B at a later date, that individual's medical coverage under the Retiree Plan will be terminated and cannot be reinstated in the future.

Retiree medical coverage when you or your covered dependent is currently enrolled in a Wells Fargo & Company pre-Medicare medical plan option and become eligible for Medicare before 65

Disabled individuals may be automatically enrolled in Medicare Part A and Part B after receiving Social Security disability benefits for 24 months. You should receive your Medicare card with your Medicare Beneficiary Identifier (MBI) in the mail three months before the disabled individual's 25th month of disability. You should follow up with CMS or Social Security in advance of your Medicare effective date to avoid any potential gap in coverage.

If you meet the eligibility criteria stated in the [“Who's eligible — Medicare eligible retirees”](#) section starting on page 1-6, to avoid a potential gap in coverage, the Medicare-eligible individual must:

- Be enrolled in Medicare Part A and Part B on the first of the month you or your Medicare-eligible dependent is eligible for Medicare.
- As soon as you receive a Medicare ID card that contains the Medicare Beneficiary Identifier (MBI), you will need to enroll in a Wells Fargo-sponsored Medicare Advantage plan.
- Before the first of the month of you or your covered Medicare-eligible dependent's Medicare effective date enroll in a Wells Fargo-sponsored Medicare Advantage plan either by enrolling online at benefitconnect.wf.ehr.com/ess or by calling Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.
- After you have enrolled, coverage will begin under the Medicare Advantage plan once CMS approves your application. The effective date of coverage is determined by CMS and is generally the first of the month following the date you elected

the Medicare Advantage coverage or the first of the month following the date you became eligible for Medicare benefits, whichever is later. If you do not provide a complete and accurate enrollment application prior to the end date of your previous coverage, you may experience a gap in coverage.

Note: Enrollment in a Wells Fargo-sponsored Medicare Advantage Plan requires you or your eligible dependent to complete all of the above steps by the required due date. Enrollment in a pre-Medicare plan option does not automatically enroll or guarantee enrollment in a Wells Fargo-sponsored Medicare Advantage Plan.

Notwithstanding the previous paragraph, if you or your covered dependent are eligible for Medicare before age 65 due to end-stage renal disease (ESRD), the Medicare-eligible individual with ESRD may not continue medical coverage through one of the medical options for retirees eligible for Medicare during the 30-month coordination period, but can continue coverage in a retiree medical option for pre-Medicare retirees due to Medicare ESRD rules. However, once the 30-month coordination period has ended, the Medicare-eligible individual with ESRD must be enrolled in Medicare Part A and Part B to continue retiree medical coverage. You must also otherwise qualify as an Eligible Retiree (as described in the “Who’s eligible — Medicare retirees” section on page 1-6), and if eligible, you must elect coverage under a Medicare Advantage plan. If the Medicare-eligible individual with ESRD is not enrolled in Medicare Part A and Part B once the 30-month coordination period has ended, or is not enrolled in a Medicare Advantage plan once the 30-month coordination period has ended, that individual’s Wells Fargo-sponsored retiree medical coverage will be dropped and that individual cannot reenroll.

Retiree medical coverage when you or your dependent is eligible for Medicare before age 65 on or before the 1st of the month following your last day of employment

If you meet the eligibility criteria stated in the “[Who’s eligible — Medicare eligible retirees](#)” section starting on page 1-6, to avoid a potential gap in coverage, the Medicare-eligible individual must:

- Be enrolled in Medicare Part A and Part B no later than the first of the month following the retiree’s last day of employment. The Medicare-eligible individual (for example, you or your Medicare-eligible dependents you choose to elect coverage for) should consider signing up for Medicare several months before you or your eligible dependent’s Medicare eligibility date, or within three months of your last day of employment, if you or your Medicare-eligible dependent are eligible for Medicare prior to your last day of employment or eligible for Medicare the 1st of the month following your last day of employment.
- After you enroll in Medicare, you will receive a Medicare ID card that contains your Medicare Beneficiary Identifier (MBI) which you will need to enroll in a Wells Fargo-sponsored Medicare Advantage plan.
- Before your last day of employment, enroll in a Wells Fargo-sponsored Medicare Advantage plan either by enrolling online at benefitconnect.wf.ehr.com/ess or by calling

Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

- After you have enrolled, coverage will begin under the Medicare Advantage plan once CMS approves your application. The effective date of coverage is determined by CMS and is generally the first of the month following the date you elected the Medicare Advantage coverage or the first of the month following the date you became eligible for Medicare benefits, whichever is later. If you do not provide a complete and accurate enrollment application prior to the end date of your previous coverage, you may experience a gap in coverage.

Notwithstanding the previous paragraph, if you or your covered dependent are eligible for Medicare before age 65 due to ESRD, the Medicare-eligible individual with ESRD may not continue medical coverage through one of the medical options for retirees eligible for Medicare during the 30-month coordination period, but can continue coverage in a retiree medical option for pre-Medicare retirees due to Medicare ESRD rules. However, once the 30-month coordination period has ended, the Medicare-eligible individual with ESRD must be enrolled in Medicare Part A and Part B to continue retiree medical coverage. You must also otherwise qualify as an Eligible Retiree (as described in the “Who’s eligible — Medicare retirees” section on page 1-5), and if eligible, you must elect coverage under a Medicare Advantage plan. If the Medicare-eligible individual with ESRD is not enrolled in Medicare Part A and Part B once the 30-month coordination period has ended, or is not enrolled in a Medicare Advantage plan once the 30-month coordination period has ended, that individual’s Wells Fargo-sponsored retiree medical coverage will be dropped and that individual cannot reenroll.

Retiree medical coverage when you or your covered dependent is currently enrolled in a Wells Fargo & Company pre-Medicare medical plan option and become eligible for Medicare at age 65

If you meet the eligibility criteria stated in the “[Who’s eligible — Medicare eligible retirees](#)” section starting on page 1-6, to avoid a potential gap in coverage, the Medicare-eligible individual must:

- Be enrolled in Medicare Part A and Part B on the first of the month you or your Medicare-eligible covered dependent turns age 65 (or the first of the month prior to turning age 65 if your or your Medicare-eligible dependent’s birthday is the first of the month). The Medicare-eligible individual (for example, you or your Medicare-eligible dependents you choose to elect coverage for in a Wells Fargo-sponsored Medicare Advantage Plan) should consider signing up for Medicare several months before you or your eligible dependent’s Medicare eligibility date.
- After you enroll in Medicare, you will receive a Medicare ID card that contains your Medicare Beneficiary Identifier (MBI) which you will need to enroll in a Wells Fargo-sponsored Medicare Advantage plan.
- Before the first of the month you or covered Medicare-eligible dependent turn age 65 (or before the first of the preceding

month turning age 65 if you or your Medicare-eligible covered dependent turns age 65 on the 1st of the month), enroll in a Wells Fargo-sponsored Medicare Advantage plan either by enrolling online at benefitconnect.wf.ehr.com/ess or by calling Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

- After you have enrolled, coverage will begin under the Medicare Advantage plan once CMS approves your application. The effective date of coverage is determined by CMS and is generally the first of the month following the date you elected the Medicare Advantage coverage or the first of the month following the date you became eligible for Medicare benefits, whichever is later. If you do not provide a complete and accurate enrollment application prior to the end date of your previous coverage, you may experience a gap in coverage.

Note: Enrollment in a Wells Fargo-sponsored Medicare Advantage Plan requires you or your eligible dependent to complete all of the above steps by the required due date. Enrollment in a pre-Medicare plan option does not automatically enroll or guarantee enrollment in a Wells Fargo-sponsored Medicare Advantage Plan.

Retiree medical coverage when you or your dependent is 65 or older on or before the 1st of the month following your last day of employment

If you meet the eligibility criteria stated in the “[Who’s eligible — Medicare eligible retirees](#)” section starting on page 1-6, to avoid a potential gap in coverage, the Medicare-eligible individual must:

- Be enrolled in Medicare Part A and Part B no later than the first of the month following the retiree’s last day of employment. The Medicare-eligible individual (for example, you or your Medicare-eligible dependents you choose to elect coverage for) should consider signing up for Medicare several months before you or your eligible dependent’s Medicare eligibility date, or within three months of your last day of employment, if you or your Medicare-eligible dependent are eligible for Medicare prior to your last day of employment or eligible for Medicare the 1st of the month following your last day of employment.
- After you enroll in Medicare, you will receive a Medicare ID card that contains your Medicare Beneficiary Identifier (MBI) which you will need to enroll in a Wells Fargo-sponsored Medicare Advantage plan.
- Before your last day of employment, enroll in a Wells Fargo-sponsored Medicare Advantage plan either by enrolling online at benefitconnect.wf.ehr.com/ess or by calling Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1
- After you have enrolled, coverage will begin under the Medicare Advantage plan once CMS approves your application. The effective date of coverage is determined by CMS and is generally the first of the month following the date you elected the Medicare Advantage coverage or the first of the month following the date you became eligible for Medicare benefits, whichever is later. If you do not provide a complete and

accurate enrollment application prior to the end date of your previous coverage, you may experience a gap in coverage.

Important information about enrollment in Medicare Part D

CMS does not allow you to have more than one Medicare prescription drug plan at a time. If you enroll (or are enrolled) in a Medicare Part D plan after your enrollment in a Wells Fargo-sponsored Medicare Advantage plan is accepted by CMS, CMS will terminate your medical and prescription drug coverage under the Medicare Advantage plan. This means your coverage under the Wells Fargo & Company Retiree Plan (and that of any covered dependents) will be terminated and you cannot reenroll in the future.

If your covered dependent enrolls in Medicare Part D after his or her enrollment in a Wells Fargo-sponsored Medicare Advantage plan is accepted by CMS, your covered dependent will be dropped from your retiree medical coverage and cannot be reinstated unless you have a Qualified Event allowing you to add him or her to your retiree medical coverage (see the “[Enrollment election changes](#)” section on page 1-24).

If you or your eligible dependents are enrolled in a stand-alone Medicare Part D plan, or a Medicare Advantage plan that includes prescription drug coverage, prior to electing a Wells Fargo-sponsored Medicare Advantage plan, CMS will automatically discontinue that coverage when your enrollment in the Wells Fargo-sponsored Medicare Advantage plan becomes effective.

Notice of creditable coverage

Group health plans that provide prescription drug coverage to Medicare-eligible persons are required to provide creditable coverage notices each year. If you and your covered dependents are not eligible for Medicare, creditable coverage is not applicable to you or your family members. If you or a covered dependent is eligible for Medicare, each of the Wells Fargo medical plan options available to Medicare-eligible participants that include prescription drug coverage is considered “creditable,” and you should not enroll in a separate Medicare Part D plan (as you will lose Wells Fargo retiree coverage). However, reimbursement for prescription drug expenses provided by the Retirement Medical Allowance Account (RMAA) is not considered creditable coverage. You may be enrolled in Medicare Part D and remain enrolled under the RMAA.

Additionally, because you do not have creditable coverage under the RMAA, it is important for you to understand your options for enrolling in Medicare Part D when you first become eligible for Medicare. If you delay Medicare Part D enrollment, it is possible you could incur a Medicare late enrollment penalty; check with Medicare for more information.

It is also important to note that the PSI RMA does not provide for prescription drug coverage and therefore does not have creditable coverage associated with it. You may be enrolled in Medicare Part D and remain enrolled under this plan. Additionally, because this plan does not have creditable coverage, it is important for you to

understand your options for enrolling in Medicare Part D when you first become eligible for Medicare. If you delay Medicare Part D enrollment, it is possible you could incur a Medicare late enrollment penalty; check with Medicare for more information.

For more information about Medicare

You can find more information about Medicare on the Medicare website at [medicare.gov](https://www.medicare.gov). You should also call Medicare at 1-800-633-4227 for more information on enrolling in Medicare when you 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.

This information about Medicare is provided for informational purposes only. Neither the Wells Fargo & Company Retiree Plan nor the Wells Fargo Retirement Service Center can provide any advice to you (or your dependents) regarding eligibility for or enrollment in Medicare. The Wells Fargo & Company Retiree Plan, the plan administrator, and Wells Fargo & Company and any of its subsidiaries or affiliates will not be responsible if you delay your enrollment in Medicare and you are subject to late enrollment penalties or surcharges. Your failure to timely enroll in Medicare Part A and Part B will result in the termination of retiree medical coverage under the Wells Fargo & Company Retiree Plan and your inability to reenroll at a later time.

Who's eligible — dependents

Dependent Eligibility

Except as provided below, if you are eligible to elect retiree medical or dental coverage and you enroll yourself within the required time period, you may also elect to cover your eligible dependents (see the [“How to enroll”](#) section on page 1-21 for more information).

Also if you meet the eligibility criteria described in the [“Who's eligible — retirees”](#) section beginning on page 1-5, but you are 65 or older or eligible for Medicare, but not eligible for a subsidy under the Plan, your pre-Medicare eligible dependents may elect coverage under the Plan.

It is your responsibility to make sure that your dependent meets the eligibility requirements. By enrolling a dependent, you are certifying that your dependent meets the stated eligibility requirements. (For more information, refer to the [“Dependent eligibility table”](#) table starting on page 1-11.)

If you do not choose to enroll your eligible dependents at the time you initially enroll in retiree medical or dental coverage, you may not add them to coverage at any time thereafter. However, if you experience a Qualified Event that permits you to add eligible dependents to retiree medical coverage, you may add newly eligible dependents to your retiree medical coverage within 60 days of the Qualified Event. Experiencing a Qualified Event does not allow you to add eligible dependents to your retiree dental coverage.

Dependents added as a result of a Qualified Event are not eligible for a retiree medical subsidy, even if the retiree remains eligible for a subsidy. Only eligible dependents added at the initial retirement date may be eligible for a retiree medical subsidy.

Surviving dependents of a Wells Fargo & Company retiree are not considered to be participants in their own right under the Plan. They may not add new dependents to the Plan through a Qualified Event.

For more information about Qualified Events, see the [“Qualified Events for the retiree medical and dental plan options”](#) section starting on page 1-25.

If, at any time after you enroll, your dependent no longer meets the eligibility requirements, you must drop your ineligible dependent. See [“Dropping ineligible dependents”](#) on page 1-29 for more information.

Retiree dental coverage eligibility

For any retiree over age 65 at the time of retirement who otherwise would have been eligible for retiree dental if not for their age, your eligible dependents under age 65 are still eligible to be enrolled in retiree dental during your initial 60-day enrollment period. If you enrolled in retiree dental during your initial enrollment period and lose your dental coverage due to turning age 65 and you cover your dependents under retiree dental, coverage continues to be available for your dependents until they are no longer eligible.

Special situations for dependents of retirees of the former Wachovia Corporation and its subsidiaries who retired before January 1, 2010

If you have questions about whether an individual is an eligible dependent, call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to speak with a representative. Certain retiree groups that were acquired by the former Wachovia have different dependent eligibility rules. Retirees of American Savings Bank and Southeast National Bank are not eligible to cover dependents under retiree health benefits (even if the retiree otherwise experiences a Qualified Event that would entitle the retiree to enroll a dependent).

Additionally, you may have deferred your retiree coverage election for yourself and any eligible dependents. If you deferred your election, contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1. Deferred elections are contingent on Wells Fargo continuing to sponsor retiree medical plan options or allowing deferred elections.

Dependent eligibility table

Refer to the pre-Medicare and Medicare eligibility information in the previous sections as well. For the medical and dental plans, eligible dependents include:

	Eligible	Not eligible
Your spouse	<ul style="list-style-type: none">• Your current spouse to whom you are legally married under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages• Your current common-law spouse in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages	<ul style="list-style-type: none">• Your spouse who is a Wells Fargo employee• Your spouse who is enrolled (for example, a retiree) in the benefit option of the Wells Fargo & Company Retiree Plan• Your spouse who does not live in the U.S. or U.S. territories• Your spouse who is eligible for Medicare and who does not have an MBI is not eligible for retiree medical coverage• Your spouse who is age 65 or older is not eligible for retiree dental coverage• Your spouse who is age 65 or older and not eligible for Medicare is not eligible for retiree medical coverage under the Wells Fargo & Company Retiree Plan• Your former spouse from whom you are legally separated or divorced, even if you are court-ordered to provide health insurance• Your spouse if you are covered as the surviving spouse or domestic partner of a Wells Fargo & Company retiree

	Eligible	Not eligible
Your domestic partner	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – You and your domestic partner have shared a single, intimate, committed relationship of mutual caring and intend to remain in the relationship indefinitely – You reside together in the same residence and live in a spouse-like relationship – You and your domestic partner are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which you reside – Neither you nor your partner is married to another person under either federal, state, or common law, and neither is a member of another domestic partnership – You and your partner are mentally competent to consent or contract – You are both at least 18 years old – You and your partner are financially interdependent, jointly responsible for each other's basic living expenses, and if asked, are able to provide documentation for three of the following: <ul style="list-style-type: none"> ◦ 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 	<ul style="list-style-type: none"> • Your domestic partner who is an employee • Your domestic partner who is enrolled in the benefit option of the Wells Fargo & Company Retiree Plan • Your domestic partner who does not live in the U.S. or U.S. territories is not eligible for retiree medical coverage • Your domestic partner who is age 65 or older or eligible for Medicare before age 65 and who does not have an MBI is not eligible for retiree medical coverage • Your domestic partner who is age 65 or older is not eligible for retiree dental coverage • Your domestic partner who is age 65 or older and not eligible for Medicare is not eligible for retiree medical coverage under the Wells Fargo & Company Retiree Plan • 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 • Your domestic partner if you are covered as the surviving spouse or domestic partner of a Wells Fargo & Company retiree

	Eligible	Not eligible
Children	<ul style="list-style-type: none"> • A child who meets one of the following eligibility criteria through the end of the month in which the child turns age 26: <ul style="list-style-type: none"> – A child who is your or your spouse’s or domestic partner’s naturally born child – A child who is your or your spouse’s or domestic partner’s legally adopted child – A child who has been placed with you or your spouse or domestic partner for adoption (“placed” means there is an enforceable legal obligation for total or partial financial support of the child in anticipation of finalizing the adoption of that child) – A child for whom you or your spouse or domestic partner are the court- or agency- appointed legal guardian or foster parent (see the “Legal guardian and foster children” section on page 1-14) • A child who meets the eligibility criteria above, is 26 or older, and is incapacitated (see the “Incapacitated children” section on page 1-14). 	<ul style="list-style-type: none"> • A child who is enrolled under a Wells Fargo-sponsored benefit plan as a dependent of an employee, as a COBRA participant, or as a dependent of a COBRA participant • A child who is covered as a dependent of another Wells Fargo retiree or as a participant under the benefit option of the Wells Fargo & Company Retiree Plan • A child who is a Wells Fargo employee • A child who is age 26 or older, unless incapacitated (see the “Incapacitated children” section starting on page 1-14) • Your child who does not live in the U.S. or U.S. territories is not eligible for retiree medical coverage • Your child who is age 65 or older or eligible for Medicare before age 65 and who does not have an MBI is not eligible for retiree medical coverage • Your child who is age 65 and not eligible for Medicare is not eligible for retiree medical coverage • Your child who is age 65 or older is not eligible for retiree dental coverage <p>Note: A surviving spouse or domestic partner of a Wells Fargo & Company retiree may not add a child to the Plan as a result of a Qualified Event.</p>

Additional information about eligible children

In addition to those listed in the table, eligible children may also include:

Legal guardian and foster children

A child for whom you or your spouse or domestic partner is the court- or agency-appointed legal guardian or foster parent is eligible for coverage until their 26th birthday, as noted in the “[Children](#)” section of the dependent eligibility table on page 1-13, as long as you or your spouse or domestic partner remain the court- or agency- appointed legal guardian or foster parent.

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

- During your initial enrollment period for the Retiree Plan
- Within 30 days prior to or 60 days after an applicable Qualified Event

Enrollment cannot be done online and must be completed by calling the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1. You will be asked to provide a copy of the court- or agency- appointed legal guardianship or foster child placement documentation to verify your dependent’s eligibility at the time of enrollment.

After the child is enrolled, you must also pay the required contributions for the child’s coverage; see the “[Cost and funding](#)” section starting on page 1-18 for more information.

Incapacitated children

Coverage is also available for an eligible child, as described in the “[Children](#)” section of the dependent eligibility table on page 1-13, who also meets all of the following:

- Is unmarried
- Is age 26 or older
- Was incapacitated (as defined below) before his or her 26th birthday and continues to be incapacitated
- Has been continually covered as an eligible dependent under a Wells Fargo health plan or other similar health plan coverage since becoming incapacitated

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

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

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

Requesting enrollment for an incapacitated dependent child is only allowed:

- During your initial enrollment period for the Retiree Plan
- Within 30 days prior to or 60 days after the end of the month in which the child’s coverage would normally end
- Within 30 days prior to or 60 days after an applicable Qualified Event

Enrollment cannot be done online and must be completed by calling the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, and returning the Incapacitated Dependent Child Statement form as requested within 30 days from the date the Retirement Service Center sends the form to you. If you return the completed Incapacitated Dependent Child Statement form within the required time period, the information provided on the form will be evaluated to determine if your dependent meets the criteria for coverage and can be enrolled (or continue coverage). You will be informed of the decision within 10 business days, assuming all information requested is provided.

If your request to enroll (or continue coverage for) an incapacitated dependent child is approved, you must also pay the required contributions for the child’s coverage. See the “[Cost and funding](#)” section on page 1-18 for more information.

You may also be required to furnish proof of incapacity and tax dependency annually to the plan administrator (or its designee) or the Retiree Plan.

Imputed income

If you cover an eligible incapacitated child who is not your tax dependent and you receive a company contribution for retiree health care 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 and local income tax purposes, if applicable). As a result, you will receive documentation to account for the applicable amount of imputed income.

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

Elections for survivors of employees

If you die while you are covered under either the Wells Fargo & Company Health Plan or the Wells Fargo & Company International Plan and you met the age and service requirements for access to the Retiree Plan options, your eligible surviving dependents who survive you may elect coverage under the Retiree Plan, as long as they elect coverage within 60 days of your death.

Your eligible surviving dependents are those who qualify as your eligible spouse, eligible domestic partner, eligible dependent children, or eligible dependent relatives, as described in the [“Who’s eligible — dependents”](#) section on page 1-10, immediately preceding your death.

In addition, your eligible surviving dependents may also qualify for a retiree medical subsidy if you would have otherwise qualified for a subsidy. Please refer to [“Appendix D: Retiree Group Tables”](#) or [“Chapter 4: Retirement Medical Allowance Account”](#), or to the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance, for more information.

Your eligible surviving dependents will be eligible to receive your retiree medical subsidy, if applicable, to apply toward the cost of medical coverage.

Participation for surviving dependents will end on the earlier of the following:

- The date of the death of the surviving dependent
- The date the individual is no longer an eligible dependent
- The end of the month that your eligible dependent child or children turn age 26

Dependent eligibility is subject to the terms and conditions described in this SPD (including Wells Fargo’s expressly reserved right to amend, modify, or terminate the retiree health benefits or retiree medical subsidy offered at any time with or without notice).

See page 1-32 for information on survivors of retirees.

Ineligible dependents

In addition to those listed as ineligible in the [“Dependent eligibility table”](#) table starting on page 1-11, 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, a dependent reaches the maximum age, a divorce of spouse, legal separation, or any other event that results in loss of eligibility), you must drop your ineligible dependent from coverage. Refer to the [“Dropping ineligible dependents”](#) section on page 1-29 for more information.

To understand the consequences of having an ineligible dependent enrolled in the plan, refer to the [“Consequences of fraudulent enrollment”](#) section on page 1-15.

Dependent eligibility certification

Your dependent’s eligibility may be certified when you first enroll that person and then again during the Annual Benefits Enrollment period. Coverage will be terminated if you do not provide such proof or certification upon request. After coverage is terminated, it will not be reinstated.

Audits of dependent eligibility

The plan administrator (or its designee), the Retiree Plan, and the applicable claims administrator or insurer reserves 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 do not provide requested documentation or it’s determined your dependent is not eligible, coverage will be terminated and consequences of fraudulent enrollment may apply.

Consequences of fraudulent enrollment

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 Retiree Plan. In addition, your dependents will lose the right to continue coverage under COBRA.

Retiree medical and dental coverage

Retiree medical coverage

An overview of the retiree benefit options, or group retiree health coverage, available for the current plan year is shown below. These plan options are geographically dependent. Please note that there are separate options for retirees and dependents who are not yet eligible for Medicare from what may be available to Medicare-eligible retirees and dependents.

Pre-Medicare and Medicare eligibility, based on location

	United States (except Hawaii) and District of Columbia	Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands (Saipan)*	Hawaii	All other Locations
Pre-Medicare eligible	HRA-Based Medical Plan HSA-Based Medical Plan Kaiser Medical Plan (Northern and Southern California)	HRA-Based Medical Plan Out of Area HRA-Based Medical Plan Out of Area	POS Kaiser Added Choice – Hawaii	No coverage
Medicare eligible	UnitedHealthcare Group Medicare Advantage Plan Kaiser Senior Advantage Plan (Northern and Southern California)	UnitedHealthcare Group Medicare Advantage Plan	UnitedHealthcare Group Medicare Advantage Plan	No coverage

*Residency within the U.S. is required to enroll and remain enrolled in retiree medical or dental coverage, unless you resided in a U.S. territory and were enrolled in retiree medical or dental coverage prior to January 1, 2020.

If you meet the applicable eligibility requirements, you can elect retiree medical coverage for yourself and your eligible dependents (see the [“Who’s eligible — dependents”](#) section starting on page 1-10.

Additional information regarding retiree health coverage options for eligible participants:

- The Wells Fargo retiree health plan options have no preexisting condition exclusions.
- For those under age 65 and not yet eligible for Medicare, you may enroll in one of the medical plan options listed in [“Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare.”](#)
- For those age 65 and older or otherwise eligible for Medicare, you may enroll in one of the medical plan options listed in [“Chapter 3: Medical Plans for Retirees Eligible for Medicare.”](#)
- Special rules apply if you or your covered dependent is eligible for Medicare before age 65 due to end-stage renal disease (ESRD). See the [“Retiree medical coverage when you or your covered dependent is currently enrolled in a Wells Fargo & Company pre-Medicare medical plan option and become eligible for Medicare before 65”](#) section starting on page 1-7 for more information.

- Retirees and/or covered dependents who are or become Medicare eligible and do not have a subsidy as described in [“Appendix D: Retiree Group Tables”](#) or in [“Chapter 4: Retirement Medical Allowance Account”](#), or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance, are not eligible for retiree medical coverage under the Wells Fargo & Company Retiree Plan.

The following statements are for informational purposes only and is not part of the official Summary Plan Description for the Wells Fargo & Company Retiree Plan:

- Retirees and their covered dependents who become Medicare eligible on or after April 1, 2018, and do not have a subsidy described in [“Appendix D: Retiree Group Tables”](#), in [“Chapter 4: Retirement Medical Allowance Account”](#), or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance, will receive additional information about other available medical coverage options. Dependents of Medicare-eligible retirees covered by the Plan on April 1, 2018, are eligible for continued retiree medical coverage under the Plan once they become Medicare eligible.

- If you were a retiree from Wachovia (or one of the companies acquired by or merged into Wachovia), you may also be eligible for one of the following:

- Retirement Medical Allowance Account (RMAA). To determine your eligibility and for more information about the RMAA, see “[Chapter 4: Retirement Medical Allowance Account](#).” Note that if you elect to apply your retirement medical allowance to a RMAA, the election is irrevocable and you may not elect a coverage option under the retiree medical plan in the future.
- Prudential Securities Inc. (PSI) RMA: Retirees of Prudential Securities Inc. who are eligible for and who previously elected a PSI RMA have received a separate Summary Plan Description for that plan option that describes eligibility along with other plan provisions. To request a copy of the PSI RMA SPD or for any questions about eligibility for the PSI RMA, call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.
- Medigap reimbursement: Participants who were employed by the former First Fidelity on January 1, 1996, retired prior to October 2, 1998, and at that time had age plus years of service equal to or greater than 75, are able to elect between medical coverage under the Wells Fargo & Company Retiree Plan and reimbursement of non-group medical coverage. Participants may change their election on an annual basis during Annual Benefits Enrollment.

If Medigap reimbursement is elected, eligible participants will be reimbursed for medical premiums up to \$750 per year for single coverage and \$1,500 per year for a retiree and an eligible spouse. In order to receive the reimbursement, participants must provide premium and enrollment information to the Wells Fargo Retiree Service Center on an annual basis.

- Deferred elections: If you were a retiree from Wachovia (or one of the companies acquired by or merged into Wachovia), you may have deferred your retiree coverage election. If you deferred your election, contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to make an election. Such elections are contingent on Wells Fargo continuing to sponsor retiree medical plan options or allow deferred elections. If you deferred your elections, upon your death, your surviving eligible dependents should contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to get more information about available options they may have, if any. More information on Deferred Elections can be found on page 1-21 under “How to enroll.”

Retiree dental coverage

If you meet applicable eligibility requirements, you can choose retiree dental coverage for yourself and your eligible dependents (see the “[Who’s eligible — dependents](#)” section starting on page 1-10). For information on retiree dental coverage, see “[Chapter 5: Retiree Dental Plan](#).”

Coordination with other coverage

When you or your dependents have other group health coverage (such as through your spouse’s or your domestic partner’s employer or through Medicare, for example), the applicable Wells Fargo-sponsored retiree health plan option 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 Wells Fargo-sponsored retiree medical, dental, and vision 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 Retiree Plan from both a medical plan option and the dental plan option for the same services.
- Wells Fargo retiree medical plans do not coordinate prescription drug benefits. For example, if you are covered under a Wells Fargo retiree medical plan option and another plan is primary, there is no secondary prescription drug benefit under the Wells Fargo retiree medical plan.

If the applicable Wells Fargo-sponsored retiree medical plan is secondary, it pays only the difference between the other plan’s benefit, if lower, and the normal Wells Fargo-sponsored retiree medical plan benefit. When the primary plan pays a benefit that equals or exceeds the normal Wells Fargo-sponsored retiree medical plan benefit, the Wells Fargo-sponsored retiree medical plan option 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 for the longest period of time is the primary plan.
 - D. If a retiree or covered dependent 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, unless a court decree stipulates otherwise, plans pay in this 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-sponsored retiree health plan option. If you receive coverage through an HMO or a Medicare Advantage plan, you may need to contact the HMO or Medicare Advantage plan directly to determine coordination of benefits.

Nonduplication of benefits

Wells Fargo pre-Medicare plans have a nonduplication of benefits coordination of benefits provision. This means that no additional payment will be made by the Wells Fargo pre-Medicare plan if the primary plan paid more than or equal to the amount the Wells Fargo pre-Medicare plan would have paid, if the Wells Fargo pre-Medicare plan was the primary plan.

The following example shows how nonduplication works (assuming that all applicable retiree medical plan option deductibles have been met).

HRA-Based Medical Plan example

Mary is a Wells Fargo retiree under age 65 and is not eligible for Medicare. John, her spouse, works for Company X. They have retiree and spouse coverage through Mary's HRA-Based Medical Plan, as well as coverage with John's employer's plan. John incurs \$1,000 in hospital room and board charges. First, John's employer's plan pays 80% (\$800). The HRA-Based Medical Plan will not make any additional payment because the primary plan already paid 80% — and that's equal to the amount that the HRA-Based Medical Plan would have paid if it had been the primary plan.

John's hospital bill	\$1,000
John's Company X plan payment as primary payer (80%)	\$800
Mary's HRA-Based Medical Plan maximum payment (80%)	\$800
Mary's HRA-Based Medical Plan actual payment as secondary payer (Retiree Plan maximum payment minus Company X payment)	\$0
John's remaining payment due	\$200

Coordination with Medicare

If you elect coverage under a Medicare Advantage plan, there is no coordination of benefits with Original Medicare. Medicare Advantage plans are a type of Medicare plan offered by a company that is contracted with Medicare to cover all Medicare Part A and B services. If you elect a Medicare Advantage plan, Medicare eligible services are paid under the plan and are not eligible for additional coverage under Medicare. For important information about retiree medical coverage once you or your covered dependent is eligible for Medicare, see the [“Important information about retiree medical coverage for Medicare-eligible individuals”](#) section starting on page 1-7.

If you or a covered dependent is eligible for Medicare as a result of ESRD, your Wells Fargo retiree medical plan coverage will be primary during the 30-month coordination period to the extent required by federal law. After the 30-month coordination period has ended, you must elect coverage in a Medicare Advantage plan and enroll in Medicare Part A and Part B. For important information about the requirement to be enrolled in Medicare Part A and Part B once the 30-month coordination period has ended, see the [“Retiree medical coverage when you or your covered dependent is currently enrolled in a Wells Fargo & Company pre-Medicare medical plan option and become eligible for Medicare before 65”](#) section starting on page 1-7.

There is no coordination of benefits for prescription drug coverage. For more information, see the [“Important information about enrollment in Medicare Part D”](#) section on page 1-9.

If you're traveling overseas, note that Medicare does not cover any services you receive outside the U.S. Similarly, the Wells Fargo medical plans do not cover services received outside the U.S.

You should contact Medicare at 1-800-633-4227 or at [medicare.gov](https://www.medicare.gov) for questions about enrolling in Medicare, coordination with Medicare, and to determine any consequences and processes applicable to delayed enrollment in Medicare Part A, Part B, or Part D. See the [“For more information about Medicare”](#) section on page 1-10.

Cost and funding

Medical and dental costs

Most retirees are responsible for the full cost of retiree medical and dental coverage.

However, if you are eligible for a retiree medical subsidy (as described in [“Appendix D: Retiree Group Tables”](#), in [“Chapter 4: Retirement Medical Allowance Account”](#), or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance), the subsidy amount will offset the cost of Wells Fargo-sponsored retiree medical coverage. Depending on the group from which you retire and your years of service for retiree medical subsidy purposes, you may be eligible for a retiree medical subsidy. Refer to [“Appendix D: Retiree Group](#)

Tables”, to “[Chapter 4: Retirement Medical Allowance Account](#)”, or to the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance, to determine if you are eligible for a retiree medical subsidy. There may be higher minimum age and service requirements to receive a subsidy than there are to participate in the retiree health plans (that is, retiree medical subsidy requirements may be different from eligibility access requirements). Age and years of service, if applicable to a subsidy calculation, will be calculated as of December 31, 2015, for any retirements on or after January 1, 2016. This means that after December 31, 2015, you will no longer be credited with any additional subsidy amount under the plan.

Years of service are calculated based on full years. If you have a break in service of greater than six months, your years of service will be recalculated based on your corporate rehire date. In some situations, a break in service of six months or longer may invalidate your eligibility for a retiree medical subsidy.

You and your dependent may pay different premiums due to this difference between pre-Medicare and Medicare eligibility. It is also important to note that the retiree medical subsidy for retirees in certain retiree groups is no longer available after the retiree becomes eligible for Medicare.

Subsidies are subject to change. Wells Fargo & Company may amend the Plan from time to time and reserves the right to change or terminate the Plan. Further, Wells Fargo & Company may discover and correct errors to subsidy calculations based on a review of age, service, and other eligibility data.

Retiree contribution amounts may change every plan year and may also vary based on various factors, including the number and type of dependents covered.

For cost information for COBRA continuation coverage, refer to “[Appendix E: Continuing Coverage Under COBRA](#).”

Retirement medical allowance subsidy

If you retired from Wachovia before January 1, 2010, you may be eligible for a retirement medical allowance that can be used to help pay for your Wells Fargo-sponsored retiree medical coverage or that can be applied to a Retirement Medical Allowance Account. To determine your eligibility for and the amount of a retirement medical allowance, refer to the “[Amount of annual retirement medical allowance allotted to RMAAs](#)” section in “Chapter 4: Retirement Medical Allowance Account.”

Tax implications for domestic partners and their children

The information in this section is not intended to provide tax advice. Federal and state tax laws may differ. Consult a tax advisor for information about your specific situation.

Domestic partners

Imputed income

Generally, your domestic partner (see the “[Dependent eligibility table](#)” table starting on page 1-11 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 retiree health care coverage, the portion of the company’s contribution that is for 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, retirees will receive a W-2 or a 1099 form to account for the applicable amount of imputed income. 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 the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

Qualified dependents under the Internal Revenue Code or state tax law

In certain instances, your 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 a 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 a tax advisor, you determine that 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), call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, 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).

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

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

How benefits are funded

All retiree contributions for coverage under the self-insured medical and dental plans may be deposited into a trust fund to which Wells Fargo may also make contributions. Claims and expenses associated with these plans may be paid out of the trust fund. All retiree contributions for coverage under an HMO or other fully insured coverage may be deposited into a trust fund or paid to the HMO or insurer. Claims 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 Retiree 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 retiree, participant,

dependent, or beneficiary will have any right to, or interest in, amounts deposited to a trust fund.

Benefits are paid first with plan assets, which includes any participant contributions. To the extent there are insufficient plan assets to pay benefits, the employer may but is not required to make contributions.

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

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

Payment of retiree coverage

You are responsible for the timely payment in full of your retiree coverage. The costs and monthly payment procedures for your retiree coverage will be explained in your Retiree Benefits Enrollment Statement. You may choose to pay for your retiree coverage through one of the following options.

- Enroll in Auto Pay (a direct debit or automatic premium payment from your bank account) by following the instructions included with your initial billing invoice or by calling the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, or by visiting benefitconnect.wf.ehr.com/ess. Electing to pay your recurring monthly retiree health care premiums automatically by having them deducted from your designated bank account helps ensure that your premiums are paid timely and that your health care coverage is not terminated due to nonpayment of premium.

You may access the website in the future as well to add and manage your banking account information.

- Submit payment by check or money order, along with the payment coupon, provided monthly with your billing invoice. If you use a bill-paying service, the check must include your Participant ID, which is listed on your monthly billing invoice. Payment must be received by the due date in order to not be considered a late payment.

- Use the “One Time Payment” feature on the website to pay one or more months of retiree premiums. You may designate a bank account that is the same or different from that designated for the Auto Pay program described above.

If your retiree coverage is COBRA continuation coverage, refer to [“Appendix E: Continuing Coverage Under COBRA”](#) for payment information.

First payment for retiree coverage

If a billing invoice is not received within four weeks after the later of your coverage effective date or the date you submitted your retiree coverage elections, call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

Payment in full should be received by the due date as stated in your monthly billing invoice. The first payment must include all of the months, from the coverage effective date to the end of the current month.

Do not include any additional correspondence with your payment, as it will not be reviewed.

You must wait until you receive an initial invoice before you pay your first month’s premium. You may access the Wells Fargo Retirement Service Center using one of the methods described above to access a “One Time Payment” feature to pay your first month’s premium from a bank account of your choosing.

If you elect Auto Pay, it will apply for your monthly invoices for retiree benefits after the first month. Please note that One Time Payment and Auto Pay are separate transactions in Employee Self Service on the Retirement Benefits website and you may choose to access both to set up debits to your bank accounts to cover your first month’s and ongoing retiree premiums.

Monthly payments for retiree coverage

After the first payment is made, payment in full is required in each subsequent month. For pre-Medicare coverage, if payment is not received by the due date, coverage terminates retroactive to the last day of the last month for which full payment was received. Once terminated, coverage cannot be reinstated and you cannot reenroll at a later date.

For Medicare Advantage coverage, payment must also be received by the due date. If not received, based on CMS rules, coverage will terminate prospectively at the end of the month following the end of the grace period. Coverage cannot be reinstated and you cannot reenroll at a later date. You are responsible for premium payments for your coverage up through your termination date.

Payments by check

If you have not enrolled in Auto Pay (direct debit), your monthly payments must be submitted by check or money order to the Wells Fargo Retirement Service Center, and received by the due date as indicated on the billing invoice. If the payment is not received by the due date, the subsequent billing invoice

will indicate your past due amount. There is a 30-day grace period, from the original due date, within which payment must be received for your past due amount to avoid termination of your benefits. Payments received after the grace period will be deposited before a determination is made as to whether any such payment is payment in full and received by the required due date. Late or partial payments will be refunded and will not extend your coverage. Depositing of payments should not be construed as acceptance of payment in full. If your coverage is terminated due to nonpayment of premiums, you will be responsible for making premium payments through the termination date.

The payment must be submitted with the payment coupon and sent to the address noted on your invoice or the payment may be delayed or returned.

Grace periods for monthly payments

Although monthly payments in full should be received by the due date indicated on the billing invoice, there is a 30-day grace period for the monthly payment in full to be received. If the payment in full is not received by the due date, the subsequent billing invoice will indicate a past due amount. Payment for this past due amount must be received within the 30-day grace period after the original due date, to avoid termination of coverage.

For example, under the pre-Medicare options, payment for coverage for the month of January is due and must be received by January 28. If the payment in full is not received by January 28, a new billing invoice will be sent that indicates an amount past due for the January payment, as well as any additional charges for the month of February. Under the grace period, the delinquent payment amount in full must be received on or before February 27 for the January coverage. If payment in full is not received by February 27, coverage will be terminated retroactively to December 31. Once terminated, coverage cannot be reinstated and you will not have an opportunity to reenroll at a later date.

Important notes regarding monthly billing invoices and payments

- Consider enrolling in Auto Pay to help avoid termination of coverage due to nonpayment of premium; if your coverage is terminated you will not be able to reenroll at a later date.
- If a billing invoice is not received by the middle of the month, call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, or visit benefitconnect.wf.ehr.com/ess and click on the “View My Billing Information” link to retrieve a copy.
- Mail the required payment to the address provided on the payment coupon.
- Do not include any additional correspondence with your payment.

- You are responsible for making sure that you submit monthly payments in full for continued coverage. If there are any questions concerning the billing invoice, contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.
- 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 and will not extend coverage. Depositing of payments should not be construed as acceptance of payment in full. If your coverage is terminated due to nonpayment of premiums, you will be responsible for making premium payments through the termination date.

If your retiree coverage is under COBRA continuation coverage, refer to “[Appendix E: Continuing Coverage Under COBRA](#)” for separate payment procedures.

How to enroll

Initial enrollment

If you are eligible for retiree health care coverage, this is your one-time opportunity to enroll. You must enroll yourself and any eligible dependents within 60 days of the date you retire. If you are eligible for Medicare at the time you retire, and you are also eligible for coverage and a retiree medical subsidy under a Wells Fargo & Company option, you must elect coverage under a Medicare Advantage plan prior to the first of the month in which you retire to avoid a potential gap in coverage between your coverage under the employee plan and the Medicare Advantage plan. It is very important to add eligible dependents to your coverage when you initially elect retiree medical or retiree dental coverage. You cannot add eligible dependents to retiree medical or retiree dental coverage after your initial enrollment, unless you experience a Qualified Event that permits you to add eligible dependents to retiree medical coverage (see the “[Qualified Events for the retiree medical and dental plan options](#)” section starting on page 1-25 for more information). Late-add dependents are not eligible for a subsidy even if they otherwise would have been had they been added upon your initial retirement.

You must complete your initial enrollment process online (benefitconnect.wf.ehr.com/ess) or by calling the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1. If you do not enroll during this initial enrollment period for retiree health care coverage, you will not be able to enroll at a later date. (Exception: If you were previously eligible to defer your retiree medical coverage election, contact the Wells Fargo Retirement Service Center when you want to make your retiree medical enrollment election.)

For enrollment under COBRA continuation coverage, refer to “[Appendix E: Continuing Coverage Under COBRA](#).”

Important information about enrolling eligible dependents

It is very important to add eligible dependents to coverage when you initially elect retiree medical or retiree dental coverage. You cannot add eligible dependents to retiree medical or retiree dental coverage after your initial enrollment- See the [“Who’s eligible — dependents”](#) section starting on page 1-10. However, if you experience a Qualified Event that permits you to add eligible dependents to retiree medical coverage, you may add newly eligible dependents to your retiree medical coverage within 60 days of the Qualified Event. Experiencing a Qualified Event does not allow you to add eligible dependents to your retiree dental coverage.

If you are eligible for a retiree medical subsidy, the subsidy only applies to you and those dependents you initially enrolled when you retired. If you enroll dependents after initial enrollment as a result of a Qualified Event, the subsidy amount will not increase.

Surviving dependents of a Wells Fargo & Company retiree are not considered to be participants in their own right under the Plan. They may not add new dependents to the Plan through a Qualified Event.

For more information on Qualified Events, see the [“Qualified Events for the retiree medical and dental plan options”](#) section starting on page 1-25. By enrolling a dependent, you are certifying that your dependent meets the stated eligibility requirements; see the [“Who’s eligible — dependents”](#) section on page 1-10.

Deferred elections

If you were a retiree from Wachovia (or one of the companies acquired by or merged into Wachovia), you may have deferred your retiree coverage election by not electing coverage at the time you retired. If you deferred your election, contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1. Deferred elections are contingent on Wells Fargo continuing to sponsor retiree medical plan options or allowing deferred elections.

If you retired from Wachovia before January 1, 2010, and deferred your election at the time of your retirement and had not yet made an election at the time of your death, upon your death, your eligible dependents may have an opportunity to exercise your deferred election. Surviving dependents should call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, for more information about any deferred election options that may be available to them. For deferred elections, surviving dependents must elect coverage within one year of your death. However, all deferred elections are contingent on Wells Fargo continuing to sponsor retiree medical plan options or allowing deferred elections.

If you deferred your election and are not eligible for a subsidy as described in [“Appendix D: Retiree Group Tables”](#) or [“Chapter 4: Retirement Medical Allowance Account”](#), or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance, and you are Medicare-eligible, and you chose to make an election on or after March 1, 2018, you are not eligible

for retiree medical coverage under the Wells Fargo & Company Retiree Plan. This also applies to surviving dependents who are Medicare-eligible and did not make an election before March 1, 2018.

Note: The following statement is for informational purposes only and is not part of the official Summary Plan Description for the Wells Fargo & Company Retiree Plan: Retirees that are Medicare-eligible and do not have a subsidy described in [“Appendix D: Retiree Group Tables”](#) or [“Chapter 4: Retirement Medical Allowance Account”](#), or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance, and did not make an election before March 1, 2018, will need to contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to receive information about available alternative medical coverage options not sponsored by Wells Fargo.

Benefits Confirmation Statement and corrections

You will receive a Benefits Confirmation Statement for review soon after you make your enrollment elections, either when you first retire or during Annual Benefits Enrollment. If the Benefits Confirmation Statement does not match the elections you made, call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to make corrections.

Adding eligible dependents after initial enrollment

If you are enrolled in retiree medical coverage and you experience a Qualified Event that permits you to add a dependent to coverage, you may add a new dependent to your retiree medical coverage after your initial enrollment. For more information, see the [“Qualified Events for the retiree medical and dental plan options”](#) section starting on page 1-25. (By enrolling a dependent, you are certifying that your dependent meets the stated eligibility requirements; see the [“Who’s eligible — dependents”](#) section starting on page 1-10.)

You may not, however, add dependents to your retiree dental coverage after your initial enrollment.

If you are eligible for a retiree medical subsidy, the subsidy only applies to you and those dependents you initially enrolled when you retired. If you enroll dependents after initial enrollment as a result of a Qualified Event, the subsidy amount will not increase.

For information about enrolling, call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to speak with a representative.

If your retiree coverage is COBRA continuation coverage, call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) to speak with a representative about adding your newly eligible dependent.

Reviews of enrollment and eligibility disputes

Review process

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

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

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

Corporate Benefits cannot accept requests sent by fax or email.

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

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

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

Corporate Benefits, on behalf of the plan administrator, has sole and complete discretionary authority to make decisions relating to eligibility for enrollment in the respective plans and termination of coverage in the respective plans, subject to the terms of applicable plan documents and governing federal law. Inquiries regarding eligibility and enrollment, or termination of coverage, that are within the plan administrator's authority generally are not subject to claims and appeals procedures. Corporate Benefits' determination, on behalf of the plan administrator, is conclusive and binding on all parties and is not subject to further review.

Before taking any legal action with respect to an enrollment or election determination, or termination of coverage determination, under the respective plans, you must first complete the internal administrative process described above. After completing the process, if you want to take legal action, you must do so within the statute of limitations described in the "[Agent for service](#)" section in "Appendix B: Important Notifications and Disclosures."

Payment adjustments for benefit coverage

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

- Coverage becomes effective for you, your dependents, or both, whether retroactively or prospectively, you are responsible for all contributions or premiums owed. For more information, refer to the "[Payment of retiree coverage](#)" section on page 1-20.
- Coverage is retroactively terminated, for you, your dependents, or both, any premiums paid after the coverage end date, for the coverage that is retroactively terminated, may be refunded.

When coverage begins

Initial enrollment

Your retiree coverage generally begins the first of the month after your last day of employment, provided you complete the initial enrollment election process within the required time frame and make the required payments for coverage by the due date (see the "[Payment of retiree coverage](#)" section starting on page 1-20). If you are eligible for Medicare at the time you retire, and if you are also eligible for the Wells Fargo Medicare Advantage option because you are eligible for a retiree medical subsidy as well, you must elect coverage under the Medicare Advantage plan prior to the first of the month that follows your last day of employment to avoid a potential gap in coverage between your current coverage and the Medicare Advantage plan. You should initiate enrollment in Medicare Part A and Part B at least 90 days in advance of your planned retirement date to minimize your risk of a potential gap in coverage. For eligible dependents enrolled during your initial enrollment period for retiree coverage, their coverage begins when your coverage begins. If dependents are eligible for Medicare, they also must be enrolled in Medicare Part A and Part B before they can enroll in a Wells Fargo-sponsored Medicare Advantage option. You should initiate the Medicare enrollment process 90 days prior to your planned retirement date.

For the effective date of COBRA continuation coverage, refer to "[Appendix E: Continuing Coverage Under COBRA](#)."

The Wells Fargo retiree medical and dental plan options have no preexisting condition exclusions.

Deferred elections

For retirees from Wachovia (or one of the companies acquired by or merged into Wachovia), who deferred their retiree coverage election at the time of retirement, coverage will generally begin the first of the month following the date you made your election with the Wells Fargo Retirement Service Center and you make any required payments for coverage by the due date. If you are electing the Medicare Advantage plan, your application must be approved by CMS before your coverage becomes effective. Your coverage will generally be effective the first of the month following the date you elected the Medicare Advantage coverage. Deferred elections are contingent on

Wells Fargo continuing to sponsor retiree medical plan options or allow deferred elections.

Enrollment election changes

If you make an allowed change in your retiree coverage for a reason listed in the [“Qualified Events table — retiree medical and dental plan options”](#) table starting on page 1-26, or the [“Qualified Events table — domestic partner and his or her children”](#) table starting on page 1-28, then coverage and premiums for most changes are effective the first of the month following the date of the event or the date you contact the Wells Fargo Retirement Service Center, whichever is later. You must call within 60 days of the Qualified Event and provide all the necessary information. You may also call the Wells Fargo Retirement Service Center up to 30 days before certain events (for example, marriage). If the future event does not take place as expected, you must call the Wells Fargo Retirement Service Center to drop your benefits change. The following are exceptions to the effective date of coverage:

- 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.
- Termination of coverage due to death of a spouse or domestic partner or other eligible dependent is effective on the date of death.
- Timely notification of your or your covered dependent’s early eligibility for Medicare Part A and Part B due to disability. You must notify the Wells Fargo Retirement Service Center as soon as you receive your Medicare MBI in order to ensure continuation of coverage under the Retiree Plan. See page 1-7 for more information.

Note: Premiums will not be prorated and are applicable for the month in which the participant’s death occurs.

Enrolling a newborn or newly adopted child

Your new child can be added to your retiree medical coverage only by calling the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, within 60 days of your child’s birth, adoption, or placement for adoption. Do not call the claims administrator or insurer for your coverage option directly. You must call the Wells Fargo Retirement Service Center within 60 days of your child’s birth, adoption, or placement for adoption. Changes for medical coverage will be effective as of the date of birth, adoption, or placement for adoption.

If your retiree coverage is COBRA continuation coverage, call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272) to speak with a representative about adding your newly eligible dependent within the 60-day time frame.

Annual Benefits Enrollment

If you make changes to your retiree benefit elections during the Annual Benefits Enrollment period, your new coverage goes into effect on the following January 1. For more information about Annual Benefits Enrollment election options, see the [“Annual Benefits Enrollment”](#) section starting on this page.

Changing benefit elections

This section addresses making changes to your benefit elections for retiree medical and dental coverage.

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 eligibility requirements; see the [“Who’s eligible — dependents”](#) section starting on page 1-10.

Changes are restricted

Your ability to make changes to your retiree benefit elections or coverage level for retiree medical and dental coverage is restricted except during Annual Benefits Enrollment for the next plan year. After you enroll, you cannot modify coverage during the plan year (except to drop coverage for you and/or a covered dependent) unless you experience a Qualified Event. For more information, see the [“Qualified Events for the retiree medical and dental plan options”](#) section starting on page 1-25.

Limited time to make changes

You must make changes to benefits during the published Annual Benefits Enrollment period or within 60 days of an event listed in the [“Qualified Events table — retiree medical and dental plan options”](#) table starting on page 1-26 or the [“Qualified Events table — domestic partner and his or her children”](#) table starting on page 1-28. You may also call the Wells Fargo Retirement Service Center up to 30 days before certain events (for example, marriage). If the future event does not take place as expected, you must call the Wells Fargo Retirement Service Center to drop your benefits change.

Annual Benefits Enrollment

During Annual Benefits Enrollment, you will receive information about your retiree medical plan options and instructions for making changes for the next plan year.

If you’re enrolled in a retiree medical plan option, each year during the Annual Benefits Enrollment period, you can change retiree medical plan options if another retiree medical option is available in your home address ZIP code. If you’re eligible for a retirement medical allowance, you can drop your retiree medical coverage and enroll in a Retirement Medical Allowance Account (RMAA). If you elect to apply the retirement medical allowance to an RMAA, your election is irrevocable and the retirement medical allowance will be applied to the RMAA each year. Once you drop

your coverage under a retiree medical plan option, you cannot reenroll in any retiree medical plan option in the future.

During the Annual Benefits Enrollment period, you may also drop coverage completely or change your coverage level, but only to reduce the number of dependents covered unless you experience a Qualified Event that permits you to add your new dependent. You may not otherwise change your coverage level during the Annual Benefits Enrollment period to increase the number of covered dependents. For example:

- You have retiree plus family coverage. During Annual Benefits Enrollment, you may change the coverage level to “retiree plus spouse or domestic partner” (assuming that your spouse or domestic partner is otherwise eligible for retiree coverage).
- You have retiree only coverage. During Annual Benefits Enrollment, you cannot change your coverage level to “retiree plus spouse or domestic partner” unless you experience a Qualified Event that permits you to add your spouse or domestic partner. See the [“Qualified Events for the retiree medical and dental plan options”](#) section starting on this page.

Note: Once you drop your coverage under a retiree medical or dental plan option, you cannot reenroll in the future. If you drop a dependent from your retiree coverage, you may not reenroll him or her in the future. (However, if you are still enrolled in retiree medical coverage and experience a Qualified Event you may be able to add an eligible dependent to your retiree medical coverage. For more information, see the [“Qualified Events for the retiree medical and dental plan options”](#) section starting on this page.) Dependents added through a Qualified Event are not eligible for a retiree medical subsidy.

You must make Annual Benefits Enrollment elections by the deadline specified in your Annual Benefits Enrollment materials. These changes made during the Annual Benefits Enrollment period go into effect on January 1 of the following plan year.

If you do not make changes during Annual Benefits Enrollment, coverage in each plan will continue at the same level, unless the plan is terminated or no longer available in your location, or you are no longer eligible or do not provide proof of your dependents’ eligibility.

If you don’t receive Annual Benefits Enrollment information by the end of November, call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

If your retiree coverage is COBRA continuation coverage, call BenefitConnect™ | COBRA at 1-877-29-COBRA (26272).

It is important that you notify the Wells Fargo Retirement Service Center promptly if you change your address to ensure that you receive plan communications in a timely manner. If your retiree coverage is COBRA continuation coverage, refer to [“Appendix E: Continuing Coverage Under COBRA”](#) for information on updating your address.

Qualified Events for the retiree medical and dental plan options

As a retiree, you may drop your coverage at any time, but you may never reenroll. You may only make other changes to your medical and dental coverage if you experience a Qualified Event. A Qualified Event is an event listed in the following tables. If you experience a Qualified Event, your change in coverage must be consistent with the Qualified Event. For example, you cannot add a spouse or domestic partner to coverage unless the spouse is newly eligible through marriage or the domestic partner is newly eligible through a domestic partnership. The plan administrator (in its sole discretion) shall determine whether a requested change is consistent with the Qualified Event.

To change coverage or add a dependent to coverage, you must call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, within 60 days of the event listed in the following tables. If your retiree coverage is COBRA continuation coverage, refer to [“Appendix E: Continuing Coverage Under COBRA”](#) in this *Retiree Benefits Book* for more information on changing your benefit elections.

You may also call the Wells Fargo Retirement Service Center up to 30 days before certain events (for example, marriage). If the future event does not take place as expected, you must call the Wells Fargo Retirement Service Center to cancel your benefits change.

After you make an election or 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. Call the Wells Fargo Retirement Service Center if you have questions.

Changes in coverage and premiums for most Qualified Events are effective the first of the month following the date of the event or the date you contact the Wells Fargo Retirement Service Center, whichever is later. For Medicare Advantage enrollment, the effective date will be the first of the month following the event, the date you contact the Wells Fargo Retirement Service Center, or the date of approval by CMS, whichever is later. However, if the Qualified Event is birth, adoption, or placement for adoption, your dependent’s medical coverage will be effective retroactively back to the date of birth, adoption, or placement for adoption. Any change in the cost of coverage is effective on the date the change in coverage is effective.

The tables beginning on page 1-26 describe Qualified Events under the Wells Fargo retiree medical and dental plan options. Election changes to these Wells Fargo retiree benefit plan options are permitted only upon the occurrence of one of these Qualified Events. The tables also list the election changes that are consistent with each Qualified Event.

Survivors and Qualified Events

Surviving dependents of a Wells Fargo & Company retiree are not considered to be participants in their own right under the Plan. They may not add new participants to the Plan through a Qualified Event.

Qualified Events table — retiree medical and dental plan options

Bold = Mandatory

Refer to the “[Who’s eligible — retirees](#)” and “[Who’s eligible — dependents](#)” sections for information regarding Plan eligibility.

Qualified Event	Medical and dental		
	Add coverage	Drop coverage	Change coverage
Change in marital status and death			
Your marriage	You may add your new spouse and any newly eligible dependent children to your existing retiree medical coverage.	You may drop coverage at any time, but you may never reenroll.	No
Your divorce, legal separation, annulment, or death of your spouse	You may add your eligible dependent children who lost coverage under your spouse’s plan due to divorce, legal separation, annulment, or death of your spouse to your existing retiree medical coverage.	You must drop retiree medical and dental coverage for your former spouse and any other dependents of your former spouse who are not also your dependents in the event of a divorce, legal separation, or annulment. You must drop your spouse’s retiree medical and dental coverage in the event of his or her death.*	No
Gain or loss of dependents			
Gain: Birth, adoption, or a child placed for adoption	You may add your new child to your existing retiree medical coverage.	You may drop coverage at any time, but you may never reenroll.	No
Loss: Death or marriage of a dependent child, change in child’s age or student status, or placement of your child for adoption	No	You must drop retiree medical and dental coverage for the dependent who loses eligibility.*	No
Change in your spouse’s or eligible dependent’s employment status that affects eligibility			
Job termination or change in employment status that results in your spouse’s or eligible dependent’s loss of coverage under your spouse’s or dependent’s employer’s plan	You may add your spouse or eligible dependent child who has lost coverage to your existing retiree medical coverage.	You may drop coverage at any time, but you may never reenroll.	No
New job or change in employment status that results in you, your spouse, or eligible dependent becoming eligible for coverage under your spouse’s or dependent’s employer’s plan	No	You may drop coverage at any time, but you may never reenroll.	No

* These actions are mandatory for the applicable Qualified Event

Note: Dependents added as a result of a Qualified Event are not eligible for a retiree medical subsidy. Surviving dependents may not add a new participant to the Plan.

Qualified Event	Medical and dental		
	<i>Add coverage</i>	<i>Drop coverage</i>	<i>Change coverage</i>
Loss of dependent eligibility			
Your dependent becomes ineligible for benefits	No	You must drop your ineligible dependent from retiree medical and dental coverage. ¹	No
Medicare, Medicaid, or Children's Health Insurance Program (CHIP) eligibility status change			
Your spouse or dependent is no longer entitled to Medicare, Medicaid, or CHIP (also known as SCHIPP)	You may add your spouse or eligible dependent child who has been entitled to coverage under Medicare, Medicaid or CHIP (for example, was enrolled in) and loses eligibility for such coverage to your existing retiree medical coverage (does not apply if coverage is voluntarily discontinued, including not reapplying for coverage, or loss of coverage for nonpayment of premiums), subject to all other enrollment criteria.	You may drop coverage at any time, but you may never reenroll.	No
Change in permanent residence²			
Move triggers eligibility for a new Wells Fargo benefit option (for example, moving to service area of a new plan)	No	You may drop coverage at any time, but you may never reenroll.	You may change retiree medical plans if your move results in a new plan option.
Move triggers loss of eligibility for a Wells Fargo benefit option (for example, moving outside service area of current plan)	No	You may drop coverage at any time, but you may never reenroll. Medical coverage will automatically be dropped if your home address is outside the 50 United States.	You may change retiree medical plans if the move results in loss of eligibility under your current plan option and there is another medical plan option available to you based on your home address ZIP code.

1. These actions are mandatory for the applicable Qualified Event.

2. If you have a Qualified Event as a current enrollee, you will not be able to newly enroll in the HSA-Based Medical Plan. You can only enroll in this plan during Annual Benefits Enrollment.

Note: Dependents added as result of a Qualified Event are not eligible for a retiree medical subsidy. Surviving dependents may not add a new participant to the Plan.

Qualified Events table — domestic partner and his or her children

Bold = Mandatory

Refer to the “[Who’s eligible — retirees](#)” and “[Who’s eligible — dependents](#)” sections for information regarding Plan eligibility.

Qualified Event	Medical and dental		
	Add coverage	Drop coverage	Change coverage
Change in domestic partnership			
Formation of a domestic partnership	You may add your domestic partner or his or her eligible dependent children to your existing retiree medical coverage.	You may drop coverage at any time, but you may never reenroll.	No
Termination of a domestic partnership	No	You must drop your former domestic partner and his or her children from your coverage.*	No
Death of your domestic partner	No	You must drop your deceased domestic partner and his or her children from your coverage.*	No
Gain or loss of eligibility for your domestic partner’s child			
Gain: Birth, adoption, or a child placed for adoption	You may add your domestic partner’s new eligible dependent child to your existing retiree medical coverage.	You may drop coverage at any time, but you may never reenroll.	No
Loss: Death or marriage of a dependent child, change in child’s age or student status, or placement for adoption of dependent child	No	You must drop the ineligible dependents from your coverage.*	No
Change in your domestic partner’s employment status that affects eligibility			
Job termination or change in employment status that causes loss of eligibility for medical coverage for your domestic partner or his or her children under your domestic partner’s employer’s plan	You may add your domestic partner or his or her eligible dependent children to your existing retiree medical coverage if they lose coverage under your domestic partner’s employer’s plan.	You may drop coverage at any time, but you may never reenroll.	No
New job or change in employment status that makes you or your domestic partner eligible for coverage through your domestic partner’s employer’s plan	No	You may drop coverage at any time, but you may never reenroll.	No

* These actions are mandatory for the applicable Qualified Event

Note: Dependents added as result of a Qualified Event are not eligible for a retiree medical subsidy. Surviving dependents may not add a new participant to the Plan.

Qualified Event	Medical and dental		
	Add coverage	Drop coverage	Change coverage
Medicare, Medicaid, or Children's Health Insurance Program (CHIP) eligibility status change			
Your domestic partner or his or her child is no longer entitled to Medicare, Medicaid, or CHIP (also known as SCHIPP)	You may add your domestic partner or your domestic partner's eligible dependent child who has been entitled to coverage under Medicare, Medicaid, or CHIP (for example, was enrolled in) and loses eligibility for such coverage to your existing retiree medical coverage (does not apply if coverage is voluntarily discontinued, including not reapplying for coverage, or loss of coverage for nonpayment of premiums), subject to all other enrollment criteria.	You may drop coverage at any time, but you may never reenroll.	No

Note: Dependents added as result of a Qualified Event are not eligible for a retiree medical subsidy. Surviving dependents may not add a new participant to the Plan.

Dropping ineligible dependents

When your dependent's eligibility ends (for example, a child reaches maximum age, divorce from a spouse, legal separation, or any other event that results in a loss of eligibility), you must call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, 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 an ineligible dependent.

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 the Wells Fargo Retirement Service Center that the dependent is ineligible, whichever is later. However, termination of the dependent's coverage due to death is effective on the date of death. Premiums or contributions will continue to be taken until you notify the Wells Fargo Retirement Service Center of your dependent's ineligibility. Claims incurred by an ineligible dependent after the end of the month in which coverage ends will be denied.

Dependents who lose coverage because they become ineligible may be eligible for COBRA. (See "[Appendix E: Continuing Coverage Under COBRA](#)" in this *Retiree Benefits Book* for more information.) However, if you wait longer than 60 days after the date your dependent no longer meets the dependent eligibility requirements to notify the Wells Fargo Retirement Service Center, coverage will be dropped at the end of the month following the date you notify the Wells Fargo Retirement Service Center that the dependent is ineligible and COBRA coverage will not be offered.

In the event one of your covered dependents becomes a Wells Fargo employee, he or she is no longer an eligible dependent and must be dropped from your retiree medical and dental coverage. You must call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to drop this dependent from coverage. If your coverage is COBRA continuation coverage, refer to "[Appendix E: Continuing Coverage Under COBRA](#)" for information on dropping an ineligible dependent. The dependent's coverage will end under the Retiree Plan as of the day immediately before your dependent's coverage becomes effective under the Wells Fargo & Company Health Plan. The applicable change in premium contribution for your retiree coverage will take effect on the next available billing cycle following the date you contact the Wells Fargo Retirement Service Center.

To understand the consequences of having an ineligible dependent enrolled in the plan, refer to the "[Consequences of fraudulent enrollment](#)" section on page 1-15.

Dropping your coverage

You may drop your, or a dependent's, coverage at any time during the plan year. However, if you drop coverage, you will not be able to reenroll at a later time. Your dependents' coverage will also end if you drop your coverage.

If you move

If you're planning to move, you should contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to speak with a representative as soon as you know your new address to update the company's record of your address. If your retiree coverage is COBRA continuation coverage, refer to "[Appendix E: Continuing Coverage Under COBRA](#)" for information on updating your address.

A move may 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; usually 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).
- If you move and your change in residential address is outside the 50 United States and its territories (Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, 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.
- 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 with the Wells Fargo Retirement Service Center. If your retiree coverage is COBRA continuation coverage, refer to [“Appendix E: Continuing Coverage Under COBRA”](#) for information on updating your address.

You have 60 days from the date of the move to request an enrollment change if the move results in loss of eligibility for your current plan option. Any change in coverage will be effective the first of the month following the date of the move.

If you do not request an enrollment change and your retiree medical plan is no longer available, you will be automatically enrolled in one of the retiree medical plans listed in the table on the following page based on your home address ZIP code and Medicare status. This change will be effective the first of the month following your move.

If, due to your move, you are no longer eligible for the Medicare Advantage plan in which you are enrolled, you will be disenrolled from the Medicare Advantage plan and you must complete and return a new Medicare Advantage enrollment application by contacting the Wells Fargo Retirement Service Center. See the [“Changing from one Medicare Advantage plan to another”](#) section in “Chapter 3: Medical Plans for Retirees Eligible for Medicare” for more information.

When coverage ends

Retirees

Retiree coverage ends on the last day of the month when one of the following occurs:

- You drop coverage. (**Exception:** If you make an election to drop coverage during Annual Benefits Enrollment, that coverage ends December 31 of the year in which the Annual Benefits Enrollment election was made.)
- You no longer meet the benefits eligibility requirements (including the requirement to be enrolled in Medicare Part A and Medicare Part B when applicable).
 - You are no longer eligible for medical coverage under the Retiree Plan if you become eligible for Medicare and you are not eligible for a subsidy (as described in [“Appendix D: Retiree Group Tables”](#)).
- You stop paying for coverage or premiums are not timely paid.
- You are rehired by Wells Fargo & Company (or an affiliate of Wells Fargo & Company); see the [“Rehired retirees”](#) section on page 1-31 for more information, including the effective date for termination of coverage.
- You die. (Coverage for you ends on the date of your death. Coverage for your dependents may continue; see the [“Coverage if you die”](#) section on page 1-32.)
- You are incarcerated. (CMS requires that coverage under a Medicare Advantage plan be terminated on the first of the month following the incarceration.)
- If you or your dependent is age 65 or older or otherwise eligible for Medicare, refer to the [“When coverage ends”](#) section in “Chapter 3: Medical Plans for Retirees Eligible for Medicare” for additional events that would cause coverage to be terminated.
- If you are eligible for coverage under the Wells Fargo & Company Retiree Plan due to receiving long-term disability (LTD) benefits, your coverage will end the first of the month in which you reach age 65 or the first of the month in which your LTD benefits cease, whichever is earlier.

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.

Note: If you drop your coverage or lose coverage, coverage for your dependents also ends. Coverage will not be reinstated and you may not reenroll at any time in the future. Any premiums received after the coverage end date will be refunded to you.

Rehired retirees

If you are a retiree who is rehired by Wells Fargo (or any of its affiliates) into a full-time, part-time or flexible position, you will not be able to continue your coverage under the Wells Fargo & Company Retiree Plan. Retiree coverage will terminate the day before your rehire date.

If, at the time you were rehired into a regular, part-time, or flexible position, you were enrolled in retiree medical coverage or were eligible for subsidized retiree medical coverage and were enrolled in retiree medical coverage, or if you were eligible for a retirement medical allowance as a retiree, when you retire again you may continue to be eligible, depending on the options available under the Wells Fargo & Company Retiree Plan to retirees and their eligible dependents and beneficiaries at that time. However, you will not accrue additional years of service for purposes of determining the subsidy or amount of the retirement medical allowance. If you were eligible for a subsidy when you first retired and did not elect retiree medical coverage, you will not be eligible for a subsidy when you retire again. **Note:** Rehired retirees who retire again and are eligible for Medicare (or dependents eligible for Medicare) and do not have a subsidy as described in [“Appendix D: Retiree Group Tables”](#) or in [“Chapter 4: Retirement Medical Allowance Account”](#), or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance, are not eligible for coverage under the Wells Fargo & Company Retiree Plan.

If you are a retiree who has coverage under the Wells Fargo & Company Retiree Life Insurance Plan (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.

Note: If you are a retiree who is rehired as a Wells Fargo employee, your benefits enrollment is handled like a new employee. To be covered under the benefit plans offered to employees, you, the rehired retiree, must enroll as a newly hired employee during your designated enrollment period. Upon rehire, you will be contacted by Employee Care to review your enrollment options. The preceding information regarding enrollment in the benefit plans offered to employees is for general information purposes only. The information in this “Note” is not a provision of either the Retiree Plan or the Retiree Life Insurance Plan. Additionally, this *Retiree Benefits Book* does not constitute part of the Summary Plan Description for any benefit plan offered to employees. For more information about benefit plans offered to employees, contact Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2, to request a *Benefits Book*.

Dependents

Coverage for dependents ends on the last day of the month in which you voluntarily drop your retiree coverage, you stop paying for coverage, you are rehired by Wells Fargo & Company (or an affiliate of Wells Fargo & Company), or one of the following occurs:

- For a spouse, when there is a legal separation, divorce, or annulment.
- For a domestic partner, when the partnership terminates.
- For any dependent, when they no longer meet applicable eligibility requirements.
 - For retiree dental coverage, coverage ends the last day of the month immediately preceding the month in which your dependent turns 65
- The last day of the month in which you voluntarily elect to drop coverage of a covered dependent. (**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 is incarcerated. (CMS requires that coverage under a Medicare Advantage plan be terminated on the first of the month following the incarceration.)
- If your dependent is age 65 or older or otherwise eligible for Medicare, refer to the [“When coverage ends”](#) section in “Chapter 3: Medical Plans for Retirees Eligible for Medicare” for additional events that would cause coverage to be terminated.
- Your dependent dies. (Coverage ends on the date of death.)

If, at any time after you enroll, your dependent no longer meets the eligibility requirements, you must drop your ineligible dependent. See [“Dropping ineligible dependents”](#) on page 1-29 for more information.

If the dependent becomes ineligible on the last day of the month, coverage ends on that day.

Claims incurred by the dependent after the end of the month in which coverage ends will be denied. Premiums or contributions will continue to be taken until you notify the Wells Fargo Retirement Service Center (and provide any required documentation) that your dependent is no longer eligible.

If coverage ends, and you or your dependents notify the Wells Fargo Retirement Service Center within the designated time, your dependents may be eligible for extension of coverage under COBRA (see [“Appendix E: Continuing Coverage Under COBRA”](#) in this *Retiree Benefits Book* for more information) . Your dependents will receive a COBRA Election Notice.

Coverage if you die

If you die while covered under a retiree medical or dental plan, only your eligible dependents who are covered under the Retiree Plan at the time of your death may continue coverage under the Plan. Premiums or contributions for the month in which you die must be paid in full (there is no prorating of premiums) to receive coverage for any portion of that month. If the required premiums or contributions are not received for that month, your coverage will be terminated as of the end of the month for which full payment was last received. If premiums and contributions are paid in full through the month in which you die, your spouse or domestic partner and dependent children who are covered under the retiree medical or retiree dental plan at the time of your death may continue retiree medical or retiree dental coverage by paying the required contribution. Under these circumstances, coverage may continue until they no longer meet applicable eligibility requirements or fail to make timely payments for coverage. Surviving eligible dependents who remain enrolled for coverage must continue to pay for coverage, and the cost of coverage may increase.

Survivors may not add new members to their coverage during Annual Enrollment or through a Qualified Event.

For Wachovia retirees, if you were eligible for a retirement medical allowance, 100% of your retirement medical allowance will be applied to the cost of coverage for your eligible dependents after your death for as long as the allowance continues to be offered under the Retiree Plan. The retirement medical allowance calculation is based on the retiree's date of birth. To determine your eligibility for and the amount of a retirement medical allowance, refer to the [“Amount of annual retirement medical allowance allotted to RMAAs”](#) section in “Chapter 4: Retirement Medical Allowance Account.”

Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare

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Contacts

Information (including providers in your area) about the medical plans administered by UnitedHealthcare	1-800-842-9722 myuhc.com https://www.liveandworkwell.com (access code: wellsfargo) for mental health and substance abuse services Mobile app: “UnitedHealthcare” by United Healthcare Services, Inc.
Information about prescription drug coverage administered by Express Scripts	1-855-388-0352 express-scripts.com Pre-enrollment site: express-scripts.com/wf Mobile app: “Express Scripts” by Express Scripts Holding Company
Information about the medical plans administered by Kaiser Permanente	Kaiser California (Northern and Southern) 1-800-464-4000 https://my.kp.org/wf Kaiser Hawaii 1-800-966-5955 https://my.kp.org/wf Mobile app: “Kaiser Permanente” by Kaiser Permanente
Information about retiree medical coverage options and enrollment	The Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1 benefitconnect.wf.ehr.com/ess

Medical plans by location

Medical Plan	Medical Claims Administrator	State or Territory
HRA-Based Medical Plan HSA-Based Medical Plan	UnitedHealthcare	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming
Express Scripts is the prescription drug administrator for all plans listed above		
HMO — Kaiser*	Kaiser Permanente	California
POS Kaiser Added Choice — Hawaii*	Kaiser Permanente	Hawaii

* This plan is an HMO or a fully insured medical plan under the Wells Fargo & Company Retiree Plan. The benefits described in this chapter do not apply. The descriptions of plan benefits for the various HMO — Kaiser and POS Kaiser Added Choice — Hawaii coverage options are provided in separate documentation you receive directly from or made available to you by Kaiser if you enroll in the applicable plan (visit <https://my.kp.org/wf> or [kp.org/eoc](https://my.kp.org/eoc)). The information that comprises the complete SPD for the applicable Kaiser plan is noted in “[Chapter 1: Eligibility, Enrollment, and More.](#)”

Note: Residency within the U.S. is required to enroll and remain enrolled in retiree medical or dental coverage, unless you resided in a U.S. territory and were enrolled in retiree medical or dental coverage prior to January 1, 2020. Residency within the U.S. is not required for retirees who are eligible for and are currently enrolled in or enroll in the Retiree Medical Allowance Account (RMAA) as described in “[Chapter 4: Retirement Medical Allowance Account](#)” or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance.

The information in this chapter — along with applicable sections of [“Chapter 1: Eligibility, Enrollment, and More,”](#) [“Appendix A: Claims and Appeals,”](#) [“Appendix B: Important Notifications and Disclosures,”](#) [“Appendix D: Retiree Group Tables,”](#) and [“Appendix E: Continuing Coverage Under COBRA”](#) — constitutes the Summary Plan Description (SPD) for your medical plan. In case of any conflict between the SPD, any other information provided, and the official Retiree Plan document, the Retiree Plan document governs. The self-insured retiree medical plan option in which you enroll (for retirees not yet eligible for Medicare) is considered your “medical plan.”

The basics

General information

Wells Fargo sponsors various medical plan options for retirees not yet eligible for Medicare as part of the Wells Fargo & Company Retiree Plan (the “Retiree Plan”). The Retiree Plan is a retiree 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 retiree medical plan options are described in this chapter:

- Health Reimbursement Account (HRA)-Based Medical Plan
- Health Savings Account (HSA)-Based Medical Plan

Note: The health savings account that you open in conjunction with the HSA-Based Medical Plan is not part of the Retiree 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.

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

The claims administrator may release the 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. See the [“What the medical plans cover”](#) section starting on page 2-23.

Who's eligible

Only those not yet eligible for Medicare are eligible to be enrolled in one of the medical plan options described in this chapter. For additional eligibility requirements for retiree medical coverage, refer to the following sections in “Chapter 1: Eligibility, Enrollment, and More”:

- [“Who's eligible — retirees”](#)
- [“Who's eligible — dependents”](#)

As noted in [“Chapter 1: Eligibility, Enrollment, and More”](#), residency within the U.S. is required to enroll and remain enrolled in retiree medical coverage, unless you resided in a U.S. territory and were enrolled in retiree medical coverage prior to January 1, 2020. Residency within the U.S. is not required for retirees who are eligible for and are currently enrolled in or enroll in the Retiree Medical Allowance Account (RMAA) as described in [“Chapter 4: Retirement Medical Allowance Account”](#) or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance.

You may not be covered under a retiree medical plan as both a retiree and a spouse or domestic partner of another retiree, or as a retiree and a dependent child of another retiree at the same time. Additionally, you may not be covered under the retiree medical plan if you are covered under a medical plan option of the Wells Fargo Health Plan for active employees and their eligible dependents.

If you or your dependents are or become eligible for Medicare, you are not eligible to be enrolled in the medical plans described in this chapter. For more information, refer to [“Chapter 1: Eligibility, Enrollment, and More”](#) and [“Chapter 3: Medical Plans for Retirees Eligible for Medicare.”](#)

How to enroll and when coverage begins

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

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 2-8
- [“How the HSA-Based Medical Plan works”](#) section starting on page 2-15

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 benefit elections”](#) section in “Chapter 1: Eligibility, Enrollment, and More.”

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 2-8
- “[How the HSA-Based Medical Plan works](#)” section starting on page 2-15

When coverage ends

Medical coverage for you or any enrolled dependents ends as described in the “[When coverage ends](#)” section in “Chapter 1: Eligibility, Enrollment, and More.”

Note: If you or your covered dependent is approaching Medicare eligibility, coverage in this option will end at the end the month prior to the Medicare effective date.

Cost

Most retirees contribute to pay for the cost of retiree medical coverage. For more information, refer to the “[Cost and funding](#)” section and the “[Payment of retiree coverage](#)” section in “Chapter 1: Eligibility, Enrollment, and More.”

Insured medical plan options

The following plan options are fully insured medical plans under the Wells Fargo & Company Retiree Health Plan:

- HMO - Kaiser California
- POS Kaiser Added Choice - Hawaii

Insurer and Claims administrator

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

Plan documentation

The following documents apply to the Kaiser insured options:

- The Kaiser evidence of coverage provides the descriptions of plan benefits and the process for receiving benefits from Kaiser for these insured medical plan options. Separate documentation is provided directly from or made available to you by Kaiser if you enroll in the applicable plan; (visit <https://my.kp.org/wf> or [kp.org/eoc](https://my.kp.org/eoc)).
- Information noted in the “Basics” section of “Chapter 2,” excluding the “Self-insured medical plan options” subsection

Note: Any additional information in “[Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare](#)” describing the benefits and processes related to the self-insured medical plan options listed below does not apply to these Kaiser medical plan options.

- Information (including references to applicable appendices) specified as applying to Kaiser medical plan options elsewhere in this *Retiree Benefits Book*.

Self-insured medical plan options

The following plan options are self-insured medical plans under the Wells Fargo & Company Retiree Health Plan:

- HRA-Based Medical Plan
- HSA-Based Medical Plan

Claims administrator

UnitedHealthcare is the claims administrator for the self-insured medical plan options listed above. The claims administrator provides claims administrative services.

For more information about the locations in which these plans are available, see the “[Medical plans by location](#)” table on page 2-4.

For each of these medical plans, Express Scripts 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 you are enrolled in.

Plan documentation

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

- Information noted in the following sections of “[Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare](#)”
 - The “Basics” section, excluding the “Insured medical plan options” subsection
 - All other information that follows in “[Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare](#)”
- Information (including references to applicable appendices) specified as applying to self-insured medical plan options in “[Chapter 1: Eligibility, Enrollment, and More](#)”

Providers and provider networks

Providers

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

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

Ineligible providers

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

- An unlicensed provider or a provider who is operating outside 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

Provider networks

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

For the HRA-Based Medical Plan and the HSA-Based Medical Plan, UnitedHealthcare has a national network. You have the choice to see any provider for most covered health services, and no referrals are required to see a specialist. However, it is recommended that you have a primary care physician (PCP) who you see regularly and who can coordinate your care. Depending on your location, you may be able to receive services from in-network providers. And, when you travel, if you need to see a provider while in another state, or if you have dependents living out of state, you may have in-network providers available to you throughout the U.S. Contact your claims administrator for information about the availability of in-network providers in a specific area.

When you receive services from an in-network provider, you can take advantage of 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 meet the annual deductible.

If you enrolled in one of these two plan options, and your home ZIP code is outside the network service area for UnitedHealthcare, there will be few, if any, network providers in your area.

- If you are enrolled in the **HRA-Based Medical Plan**, you will have 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. **Note:** If your home ZIP code is within the network service area for UnitedHealthcare, you are not eligible for the HRA-Based Medical Plan Out of Area coverage.
- If you are enrolled in the **HSA-Based Medical Plan**, you will have out-of-network coverage. When you use an out-of-network provider, you must meet the out-of-network annual deductible and pay the out-of-network coinsurance, even if you do not have access to a network physician or hospital.

UnitedHealthcare provider networks

UnitedHealthcare is the claims administrator for the HRA-Based Medical Plan and the HSA-Based Medical Plan. 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 and the HSA-Based Medical Plan administered by UnitedHealthcare. You may identify in-network providers on the UnitedHealthcare website at myuhc.com.

Important terms

Annual deductible

The annual deductible is the amount that you must pay 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, eligible 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. The in-network and out-of-network 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:

- [“How the HRA-Based Medical Plan works”](#) section starting on page 2-8
- [“How the HSA-Based Medical Plan works”](#) section starting on page 2-15

The annual deductible is referred to as “deductible” in the [“Services covered under the medical plans”](#) cost-sharing tables that start on page 2-25.

The following do not count toward the annual deductible in the HRA-Based Medical Plan (including applicable Out of Area coverage) or the HSA-Based Medical Plan:

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

- Prescription drug copays and costs
 - Charges for the difference in cost between a generic drug and a brand-name drug if a brand-name drug is selected when a generic is available
 - Out-of-network prescription drug charges for the difference in cost between the full cost and the Express Scripts discounted amount

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 Retiree Plan before the medical plan begins to pay 100% of the eligible expense for covered health services, subject to certain limitations described below. The annual out-of-pocket maximum includes the annual deductible, copays, and the per-plan-year coinsurance.

If you cover dependents, eligible expenses for all covered members accrue toward the applicable 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. 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 2-8
- [“How the HSA-Based Medical Plan works”](#) section starting on page 2-15

The annual deductible is referred to as “deductible” in the [cost-sharing tables](#) starting on page 2-26.

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

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

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 2-23 and the [“Prescription drug benefit”](#) section starting on page 2-85.

Copay

The copay is a fixed dollar amount you pay for prescription drugs under the HRA-Based Medical Plan. Generally copays are paid to the pharmacy or billed by Express Scripts Home Delivery at the time you receive the prescription. You cannot use any remaining HRA balance to pay a copay.

For more information about prescription drug coverage and copays, see the [“Prescription drug benefit”](#) section starting on page 2-85.

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 if you were enrolled in the active Copay Plan with HRA just prior to your retirement, and if you had a remaining HRA balance as an active employee. For more information, see the [“Health reimbursement account \(HRA\)”](#) section starting on page 2-9, the [“Covered health services definition”](#) section on page 2-23, and the [“Eligible expenses \(allowed amount\) definition”](#) section starting on page 2-24. 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.

- Any remaining HRA dollars pay 100% of eligible expenses for covered health services until the available HRA dollars are exhausted for services subject to the applicable 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 in-network (or if applicable, Out of Area coverage) annual deductible, except as otherwise noted in the [“Services covered under the medical plans”](#) cost-sharing tables that start on page 2-25. For information on what you'll pay for [prescription drugs](#), see page 2-85.

- After you satisfy the applicable annual deductible:
 - For in-network services and Out of Area coverage, you will typically pay 20% coinsurance for your share of eligible expenses for most covered health services received.
 - For out-of-network services, you will typically pay 40% 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 2-25 and the corresponding [cost-sharing tables](#) starting on page 2-26 for more specific information on in-network, out-of-network, and Out of Area coverage cost-sharing percentages and other requirements for covered health services.

- Prescription drug copays apply regardless of whether or not you have met the annual deductible for medical services. Refer to the “[Prescription drug benefit](#)” section starting on page 2-85 for information about what you will pay for prescription drugs.
- The use of HRA dollars does not apply to prescription drug expenses or expenses not covered by the plan.
- For certain covered health services (or prescription drugs) not subject to the annual deductible, the applicable coinsurance or copays do not apply toward the annual deductible, but they do count toward the annual out-of-pocket maximum.
- After you satisfy the applicable annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services for the remainder of the plan year (for example, if you have met the in-network annual out-of-pocket maximum, the plan will pay 100% of eligible expenses for covered health services received from an in-network provider for the remainder of the year, but it would not pay 100% of expenses for services received from an out-of-network provider until the out-of-network out-of-pocket annual maximum has been met).
- Additional information about services received from in-network providers:
 - The in-network provider should request any required pre-service authorizations for you. However, it’s your responsibility to ensure that the necessary pre-service authorizations have been received before services are provided. For more information, see the “[Pre-service authorization requirements](#)” section starting on page 2-20.
 - 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 not responsible for any charges the in-network provider must write off as a result of its contract with UnitedHealthcare or UnitedHealthcare’s associated networks.

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

- Additional information about services received from out-of-network providers:
 - You must contact UnitedHealthcare to receive required pre-service authorizations for certain services (see the “[Pre-service authorization requirements](#)” section starting on page 2-20) 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 of charges. (See the “[Claims and appeals](#)” section starting on page 2-81 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 the date of service.
 - You pay 100% for 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. 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.

Health reimbursement account (HRA)

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 previously allocated to an HRA are not vested and are subject to forfeiture. Wells Fargo & Company reserves the unilateral right to amend or modify the HRA at any time for any reason, with or without notice, including placing limitations or restrictions on amounts allocated to an HRA or terminating the HRA.

You can use the available balance in your HRA to pay for eligible expenses. If you don’t use all of your HRA dollars and you remain enrolled in the HRA-Based Medical Plan the following year, any remaining HRA dollars 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.

For more information about HRA dollars, refer to the “[Health Reimbursement Account \(HRA\)-Based Medical Plan: Annual deductible and annual out-of-pocket maximum](#)” table on page 2-14.

HRA dollars are subject to all of the following restrictions:

- HRA dollars may only be used for 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.
- You will forfeit all amounts allocated to your HRA if your HRA-Based Medical Plan coverage is terminated or waived for any reason at any time.
- You will forfeit all amounts allocated to your HRA once you turn 65 or become eligible for Medicare, whichever comes first, because the HRA-Based Medical Plan is not available to retirees or dependents who are eligible for Medicare.

However if you have a dependent that will remain on the HRA-Based Medical Plan because they are not yet eligible for Medicare, the HRA balance remaining will be applied to eligible claims for the dependent still enrolled.

- HRA dollars are a plan design feature, are not portable, and are not a guaranteed benefit.

When your retiree medical coverage ends, any remaining HRA dollars will be forfeited.

If you are enrolled in the HRA-Based Medical Plan in 2021, you can keep track of the available balance in your HRA by going online to myuhc.com 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 balance in your HRA will automatically be applied to your eligible expenses for covered health services under the HRA-Based Medical Plan.

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

If you enroll midyear in the HRA-Based Medical Plan under the Wells Fargo & Company Retiree Plan, you may be 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 more information about HRA annual deductible and annual out-of-pocket maximum, refer to the [“Health Reimbursement Account \(HRA\)-Based Medical Plan: Annual deductible and annual out-of-pocket maximum”](#) table on page 2-14.

Initial retirement

If you were not enrolled in the Copay Plan with HRA under the Wells Fargo & Company Health Plan (“Health Plan”) as an active employee immediately preceding your retirement but elect to enroll in the HRA-Based Medical Plan under the Wells Fargo & Company Retiree Plan (“Retiree Plan”) at the time of retirement, the annual deductible and annual out-of-pocket maximum under the retiree HRA-Based Medical Plan are not prorated. For example, if you enroll midyear with coverage effective July 1 at the you only (individual) coverage level, for the remainder of this plan year at this coverage level the following would apply:

- In-network annual deductible of \$3,500.
- In-network annual out-of-pocket maximum of \$5,250.

Expenses incurred before your coverage effective date in the retiree HRA-Based Medical Plan do not count toward the annual deductible or the annual out-of-pocket maximum under the retiree HRA-Based Medical Plan. For more information on annual amounts, refer to the [“Health Reimbursement Account \(HRA\)-Based Medical Plan: Annual deductible and annual out-of-pocket maximum”](#) table on page 2-14.

If you were enrolled in the Copay Plan with HRA under the Health Plan as an active employee immediately preceding your retirement and you elect to enroll in the HRA-Based Medical Plan under the Retiree Plan as a retiree, any remaining HRA dollars in your HRA as an active employee are eligible to be transferred to your HRA as a retiree if there has been no lapse in coverage. Any remaining HRA balance from your active employee Copay Plan with HRA coverage will be transferred by HealthEquity to the HRA-Based Medical Plan under the Retiree Plan, administered by UnitedHealthcare. This transfer will generally occur 60 days after you transition from the Copay Plan with HRA as an active employee to the HRA-Based Medical plan as a retiree. This is to ensure HealthEquity is able to process any claims that were incurred but not submitted for reimbursement at the time your active coverage under the Copay Plan with HRA ended.

If you were enrolled in the Copay Plan with HRA under the Health Plan as an active employee immediately preceding your retirement and you elect to enroll in the HRA-Based Medical Plan under the Retiree Plan as a retiree, the amounts applied to your annual deductible and annual out-of-pocket maximums for your current year’s Copay Plan with HRA are eligible to be applied to your current year’s HRA-Based Medical Plan coverage.

- The current year’s annual deductible and annual out-of-pocket maximum accruals will automatically be credited to the HRA-Based Medical Plan under the Retiree Plan after 60 days if your claims administrator for the Copay Plan with HRA was UnitedHealthcare.
- If your claims administrator for the Copay Plan with HRA was Anthem BCBS or Aetna, and you want your annual deductible and annual out-of-pocket maximum accruals from your current year’s Copay Plan with HRA to be credited to your HRA-Based Medical Plan, you will need to provide your last Copay Plan with HRA explanation of benefits (EOB) from Anthem BCBS or Aetna, as applicable, to UnitedHealthcare to have your records updated. UnitedHealthcare will contact your previous claims administrator to verify the accuracy of the EOB and ensure that coverage was continuous.

The following additional rules apply:

- If your coverage level remains the same under your retiree coverage as it was when you were an employee, the annual deductible and annual out-of-pocket maximum requirements under the retiree HRA-Based Medical Plan must be met; they are not prorated. Any amounts previously applied to the current year’s annual deductible and annual out-of-pocket maximum (for eligible expenses incurred by you or eligible dependents that you covered under the Copay Plan with HRA benefit option of the Health Plan and who remain covered under your election

for the HRA-Based Medical Plan benefit option of the Retiree Plan) will transfer (as described on the previous page) to the retiree HRA-Based Medical Plan. Lifetime benefits accruals for infertility treatment and transplant services will also transfer to the retiree HRA-Based Medical Plan.

- If you increase your coverage level at retirement to cover an eligible spouse or other eligible dependent (for example, if you had you only (individual) coverage when you were an employee and elect you + spouse coverage as a retiree), the annual deductible and annual out-of-pocket maximum for the retiree coverage 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 for your new coverage level under the retiree HRA-Based Medical Plan for that plan year. Amounts applied to the current year's annual deductible and annual out-of-pocket maximum for you under your employee coverage will transfer (as described on the previous page) to the retiree HRA-Based Medical Plan. Lifetime benefits accruals for infertility treatment and transplant services will also transfer.

Expenses incurred before the effective date of the increased coverage level by the individuals added to your coverage do not count toward the adjusted annual deductible or annual out-of-pocket maximum for your increased coverage level even if these individuals had coverage separately under the Copay Plan with HRA before being added to your coverage. In addition, if the person added to your coverage was previously enrolled in the Copay Plan with HRA 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.

- If you decrease your level of coverage at retirement (for example, if you had you + spouse coverage when you were an employee and elect you only (individual) coverage as a retiree), your annual deductible and annual out-of-pocket maximum are adjusted downward under the retiree HRA-Based Medical Plan to the new you only (individual) coverage level for that plan year, but are not prorated. You are required to meet the full year annual deductible and annual out-of-pocket maximum for your new coverage level, regardless of your effective date of coverage. Amounts that applied to the current year's annual deductible and annual out-of-pocket maximum under your Copay Plan with HRA coverage when you were an employee that were incurred by the individuals who continue to be covered under your retiree coverage will be applied (as described on the previous page) to the adjusted annual deductible and annual out-of-pocket maximum for the retiree HRA-Based Medical Plan for that plan year. (For example, if you had you + spouse coverage and drop coverage for your spouse, the charges previously incurred by your spouse will not count toward the adjusted annual deductible and annual out-of-pocket maximum for the plan year, even if those same charges were previously applied to the annual deductible or annual out-of-pocket maximum when your spouse was covered.) Lifetime benefits accruals for infertility and transplant services will also transfer.

Midyear enrollment due to a change in medical plan benefit option

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. For example, you may lose retiree medical coverage under the HMO — Kaiser or the POS Kaiser Added Choice — Hawaii plan option as a result of a change in residential address. If you elect to enroll in the HRA-Based Medical Plan midyear as a result of your change in residential address, the annual deductible and annual out-of-pocket maximum are not prorated under the retiree HRA-Based Medical Plan for that plan year. For more information on annual amounts, refer to the [“Health Reimbursement Account \(HRA\)-Based Medical Plan: Annual deductible and annual out-of-pocket maximum”](#) table on page 2-14. Expenses incurred before your effective date under the retiree HRA-Based Medical Plan do not count toward the annual deductible or the annual out-of-pocket maximum under the retiree HRA-Based Medical Plan.

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

If you experience a midyear Qualified Event (see the [“Qualified Events for the retiree medical and dental plan options”](#) section in “Chapter 1: Eligibility, Enrollment, and More”) 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 may be adjusted, as described in more detail below. 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 annual deductible and annual out-of-pocket maximum are adjusted to your new coverage level for that plan year, minus any HRA dollars used in that plan year. Any unused HRA dollars that had rolled over from previous plan years will remain in your HRA. Expenses incurred before the effective date of the increased coverage level by the individuals added to your coverage do not count toward the adjusted annual deductible or annual out-of-pocket maximum for your increased coverage level even if these individuals had coverage separately under the HRA-Based Medical Plan before being added to your coverage. In addition, if the person added to your coverage 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.

When your coverage level decreases due to a Qualified Event, any unused HRA dollars that had rolled over from previous plan years will remain in your HRA. However, your annual deductible and annual out-of-pocket maximum are adjusted to the new coverage level for that plan year, but are not prorated. You are required to meet the full year annual deductible and annual out-of-pocket maximum for your new coverage level, regardless of your effective date of coverage. Additionally, only amounts that applied to the current year's annual deductible and annual out-of-pocket maximum under the previous coverage level that were incurred by individuals who continue to be covered under your decreased coverage level will be applied to the adjusted annual deductible and annual out-of-pocket maximum for the plan year. Charges incurred by any other individual (even if applied to the annual deductible or annual out-of-pocket maximum for your previous coverage level) do not count toward the adjusted annual deductible and annual out-of-pocket maximum for your decreased coverage level. For example, if you had you + spouse + children coverage and drop coverage for your spouse, the charges previously incurred by your spouse will not count toward the adjusted annual deductible and annual out-of-pocket maximum for the plan year, even if those same charges were previously applied to the annual deductible or annual out-of-pocket maximum when your spouse was covered.

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

COBRA enrollment

Former or ineligible employee who elects COBRA

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

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

Dependent who elects COBRA

If your covered dependent is no longer eligible for coverage under your HRA-Based Medical Plan coverage and elects COBRA coverage under the HRA-Based Medical Plan, any charges that were incurred by the dependent and applied toward the current plan year annual deductible and annual out-of-pocket maximum before the dependent's last day of coverage will count toward the dependent's deductible and annual out-of-pocket maximum under their HRA-Based Medical Plan COBRA continuation coverage for the same plan year. Also see the "[Health Savings Account \(HSA\)-Based Medical Plan: Annual deductible and annual out-of-pocket maximum](#)" section starting on page 2-18 for other information related to a midyear enrollment.

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

- An employee covers their spouse as a dependent under the HRA-Based Medical Plan for the 2021 plan year. The employee and spouse divorce on August 10, 2021, and the former spouse's coverage ends effective August 31, 2021. If your HRA balance on August 31, 2021, was \$1,600, and your former spouse elects COBRA continuation coverage under the HRA-Based Medical Plan, your former spouse's HRA under their HRA-Based Medical Plan COBRA coverage would be credited with a \$1,600 balance.
- An employee covers their child as a dependent under the HRA-Based Medical Plan for the 2021 plan year. The child turns age 26 on May 15, 2021, and the child's coverage ends effective May 31, 2021. If your HRA balance on May 31, 2021, was \$500, and your child elects COBRA continuation coverage under the HRA-Based Medical Plan, your child's HRA under their HRA-Based Medical Plan COBRA coverage would be credited with a \$500 balance.

Lifetime benefit accruals transfer under COBRA

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

If you are rehired as an employee

When you are rehired as an active employee, your HRA-Based Medical Plan coverage under the Wells Fargo & Company Retiree Plan (“Retiree Plan”) terminates the day immediately preceding the day of your rehire.

If you do not elect the Copay Plan with HRA coverage under the Wells Fargo & Company Health Plan (“Health 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, including applying any remaining HRA dollars to such claims. Thereafter, any remaining HRA dollars will be forfeited.

Refer to the *Benefits Book* for information about eligibility, enrollment, and electing the Copay Plan with HRA coverage (or another available coverage option) under the Health Plan as a benefits-eligible employee. The information in the *Benefits Book* does not constitute any part of the Retiree Plan and is not considered part of the Retiree Plan SPD.

If you elect the Copay Plan with HRA coverage under the Health Plan as an employee, for claims incurred prior to the date your HRA-Based Medical Plan coverage terminates under the Retiree Plan, the claims administrator for your coverage under the Retiree Plan will:

- Continue to process any eligible medical claims incurred before the effective date of your change in coverage and filed within 12 months of the date of service.
- Your current year’s annual deductible and annual out-of-pocket maximum accruals under the Retiree Plan HRA-Based Medical Plan will be credited automatically toward the current year’s annual deductible or annual out-of-pocket maximum, as applicable, for the Copay Plan with HRA under the Health Plan if your claims administrator for the Copay Plan with HRA is UnitedHealthcare.
- If your claims administrator for the Copay Plan with HRA under the Health Plan will be Anthem BCBS or Aetna and you want your current year’s annual deductible and annual out-of-pocket maximum accruals under the HRA-Based Medical Plan to be credited toward the Copay Plan with HRA coverage, you will need to provide your last HRA-Based Medical Plan EOB from UnitedHealthcare to your new claims administrator. Your claims administrator will contact UnitedHealthcare to verify the accuracy of the EOB and ensure that coverage was continuous.
- Lifetime benefits accruals for infertility and fertility services and treatment will continue to accrue.
- Retain your HRA dollars, if any, for 60 days to apply to eligible medical claims incurred prior to the termination of coverage under the Retiree Plan.

- 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 Retiree 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 Health Plan.

Note: If your retiree medical coverage under the Retiree Plan is an option other than the HRA-Based Medical Plan, none of your previous expenses under the Retiree Plan will be credited toward the annual deductible or annual out-of-pocket maximum, for the Copay Plan with HRA under the Active Health Plan.

When you become ineligible for coverage or drop coverage

If you become ineligible for coverage or you voluntarily drop your coverage, your coverage ends at the end of the month. If you elect another medical benefit option under the Wells Fargo & Company Retiree 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 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 your dependent becomes ineligible for coverage, his or her coverage ends at the end of the month unless he or she elects COBRA continuation coverage for the HRA-Based Medical Plan during his or her initial COBRA enrollment period. For more information on general requirements for COBRA continuation coverage, see [“Appendix E: Continuing Coverage Under COBRA.”](#) For more information on enrollment in the HRA-Based Medical Plan under COBRA, see the [“COBRA enrollment”](#) section starting on page 2-12.

When COBRA coverage ends, any HRA dollars remaining at the time the 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.

Note: Coverage for a deceased individual ends on the date of death and retiree premiums are due for the month in which the participant passes away.

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

These amounts apply to individuals enrolled in the retiree HRA-Based Medical Plan and are subject to the procedures, exclusions, and limitations in this chapter. Please note that when you initially retire, if you elect to enroll in the HRA-Based Medical Plan under the Wells Fargo & Company Retiree Plan, any remaining HRA dollars in your HRA under the Wells Fargo & Company Health Plan as an active employee will transfer to your retiree HRA. Refer to the “[Prescription drug benefit](#)” section starting on page 2-85 for information about how prescription drugs are covered.

Annual deductible	Your annual deductible responsibility		
	In-network providers	Out-of-network providers	Out of Area coverage ²
You	\$3,500	\$6,000	\$3,500
You + spouse ¹	\$6,000	\$8,000	\$6,000
You + children	\$6,000	\$8,000	\$6,000
You + spouse ¹ + children	\$6,500	\$12,000	\$6,500

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

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

Annual out-of-pocket maximum	Your annual out-of-pocket maximum responsibility		
	Includes deductible		
Coverage level	In-network providers	Out-of-network providers	Out of Area coverage ²
You	\$5,250	\$9,250	\$5,250
You + spouse ¹	\$7,875	\$13,875	\$7,875
You + children	\$7,875	\$13,875	\$7,875
You + spouse ¹ + children	\$10,500	\$18,500	\$10,500

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.

How the HSA-Based Medical Plan works

The HSA-Based Medical Plan is a high-deductible medical plan that is compatible with a health savings account (HSA) and is available nationwide, except in the state of Hawaii.

The HSA that you set up separately is not part of the Retiree 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.”](#)

The medical plan covers eligible expenses for covered health services. (See the [“Covered health services definition”](#) section on page 2-23 and the [“Eligible expenses \(allowed amount\) definition”](#) section on page 2-24 for more information.) Below is additional information to help you understand how the plan works.

- You pay 100% of eligible expenses for covered health services until you satisfy the in-network annual deductible, except as otherwise noted in the [“Services covered under the medical plans”](#) cost-sharing tables that start on page 2-25 and for [prescription drugs](#), see page 2-85 for information about what you will pay for prescription drugs.
- After you satisfy the applicable annual deductible:
 - For in-network services you will typically pay 10% coinsurance for your share of eligible expenses for most covered health services.
 - For out-of-network services, you will typically pay 30% 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 2-25 and the corresponding [cost-sharing tables](#) starting on page 2-26 for more specific information on in-network and out-of-network cost-sharing percentages and other requirements for covered health services.

Refer to the [“Prescription drug benefit”](#) section starting on page 2-85 for information about what you will pay for prescription drugs.

- After you satisfy the applicable annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services for the remainder of the plan year (for example, if you have met the in-network annual out-of-pocket maximum, the plan will pay 100% of eligible covered expenses for covered health services received from an in-network provider for the remainder of the year, but it would not pay 100% of expenses for services received from an out-of-network provider until the out-of-network out-of-pocket annual maximum has been met).
- For certain covered health services (and drugs on the preventive drug therapy list) not subject to the annual deductible, the applicable coinsurance does not count toward the annual deductible, but it does count toward the annual out-of-pocket maximum.

- Additional information about services received from in-network providers:
 - The in-network provider should request any required pre-service authorizations for you. However, it’s your responsibility to ensure that the necessary pre-service authorizations have been received before services are provided. For more information, see the [“Pre-service authorization requirements”](#) section starting on page 2-20.
 - The in-network provider will file claims for you.
- You pay 100% for services and expenses not covered under the medical plan; however, you are not responsible for any charges an in-network provider must write off as a result of its contract with the claims administrator or claims administrator’s associated networks.

For more information on in-network providers, see the [“Providers and provider networks”](#) section starting on page 2-6.
- Additional information about services received from out-of-network providers:
 - You must contact UnitedHealthcare to receive required pre-service authorization for certain services (see the [“Pre-service authorization requirements”](#) section starting on page 2-20) 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 2-81). If the out-of-network provider files claims for you, then you are responsible for ensuring the provider follows the plan’s claims filing requirements, including filing a claim within 12 months from the date of service.
 - You pay 100% of expenses above the considered eligible expenses. An out-of-network provider can bill you for all expenses the plan does not cover, including those above the eligible expense (or allowed amount), and you are responsible for payment to the out-of-network provider. The difference between the out-of-network provider’s charges and the eligible expense (allowed amount) under the medical plan is not applied toward the annual deductible, coinsurance amounts, or annual out-of-pocket maximum and is your responsibility. This applies to all out-of-network services described in this chapter.
 - You pay 100% for services and expenses not covered by the medical plan.

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

Initial retirement

When you initially retire, if you were enrolled in the Higher Use Plan with HSA, Lower Use Plan with HSA, or Narrow Network Plan with HSA under the Wells Fargo & Company Health Plan (“Health Plan”) as an active employee immediately preceding your retirement and you elect to enroll in the HSA-Based Medical Plan under the Wells Fargo & Company Retiree Plan (“Retiree Plan”) as a retiree:

- If your coverage level remains the same under your retiree coverage as it was when you were an employee, the annual deductible, annual out-of-pocket maximum, and lifetime benefits accruals for infertility treatment and transplant services will transfer and apply to your coverage under the Retiree Plan. If the annual deductible or annual out-of-pocket maximum under the Wells Fargo & Company Retiree HSA-Based Medical Plan is higher than in the HSA-Based option Higher Use Plan with HSA, Lower Use Plan with HSA, or Narrow Network Plan with HSA you were enrolled in as an employee, you will need to satisfy the higher amounts under the Retiree Plan HSA-Based Medical Plan, even if you had already met the deductible or out-of-pocket maximums as an employee.
- If you increase your coverage level at retirement to cover an eligible spouse or other eligible dependent (for example, if you had you only coverage when you were an employee and you elect you + spouse coverage as a retiree), 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 for your new coverage level. For example, if your retiree medical coverage is effective July 1 at the you + spouse coverage level, you would be required to meet the full \$4,500 in-network annual deductible, and the \$7,500 in-network annual out-of-pocket maximum would apply.

Expenses incurred before the effective date of the increased coverage level by individuals added to your coverage do not count toward the adjusted annual deductible or annual out-of-pocket maximum for your increased coverage level, even if these individuals had coverage separately under the Higher Use Plan with HSA, Lower Use Plan with HSA, or Narrow Network Plan with HSA options before being added to your coverage.

Amounts previously applied to your current year’s annual deductible and annual out-of-pocket maximum (for eligible expenses incurred by you or eligible dependents that you covered under the Higher Use Plan with HSA, Lower Use Plan with HSA, or Narrow Network Plan with HSA of the Health Plan and who remain covered under the HSA-Based Medical Plan benefit option of the Retiree Plan) will apply to the annual deductible and annual out-of-pocket maximum for coverage under the Retiree Plan. Lifetime benefits accruals for infertility treatment and transplant services will transfer and apply to your coverage under the Retiree Plan.

- If you decrease your level of coverage at retirement (for example, if you had you + spouse coverage when you were an employee and you elect you only coverage as a retiree), 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 for your new coverage level for that plan year. (For example, if your retiree medical coverage is effective July 1 at the you only coverage level, you would be required to meet the full \$3,000 in-network annual deductible, and the \$5,000 in-network annual out-of-pocket maximum would apply.)

Amounts previously applied to your current year’s annual deductible and annual out-of-pocket maximum (for eligible expenses incurred by you or eligible dependents that you covered under the Higher Use Plan with HSA, Lower Use Plan with HSA, or Narrow Network Plan with HSA of the Health Plan and who remain covered under the HSA-Based Medical Plan benefit option of the Retiree Plan) will apply to the annual deductible and annual out-of-pocket maximum for coverage under the Retiree Plan. Lifetime benefits accruals for infertility treatment and transplant services will transfer and apply to your coverage under the Retiree Plan. If the annual deductible or annual out-of-pocket maximum under the Wells Fargo & Company Retiree HSA-Based Medical Plan is higher than in the Higher Use Plan with HSA, Lower Use Plan with HSA, or Narrow Network Plan with HSA you were enrolled in as an employee, you will need to satisfy the higher amounts under the Retiree Plan HSA-Based Medical Plan, even if you had already met the deductible or out-of-pocket maximums as an employee.

When you initially retire, if you were not enrolled in the Higher Use Plan with HSA, Lower Use Plan with HSA, or Narrow Network Plan with HSA under the Health Plan as an active employee immediately preceding your retirement but elect to enroll in the HSA-Based Medical Plan under the Retiree Plan at the time of retirement (or if you enroll midyear in the HSA-Based Medical Plan for any other allowed reason), 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 for the coverage level you elect under the retiree HSA-Based Medical Plan. (For example, if your retiree medical coverage is effective July 1 at the you + spouse coverage level, you would be required to meet the full \$4,500 in-network annual deductible, and the \$7,500 in-network annual out-of-pocket maximum would apply.)

Expenses incurred before your effective date of coverage in the HSA-Based Medical Plan under the Retiree Plan do not count toward your annual deductible or annual out-of-pocket maximum.

Midyear enrollment as a result of a change in medical plan benefit option

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). If you elect to enroll in the HSA-Based Medical Plan midyear as a result of your change in residential address, you will be subject to the full year annual deductible and annual out-of-pocket maximum under the retiree HSA-Based Medical Plan for your elected coverage level regardless of your effective date of coverage under the plan. Expenses incurred prior to your effective date in the HSA-Based Medical Plan will not apply to your HSA-Based Medical Plan annual deductible or annual out-of-pocket maximum.

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

If you experience a midyear Qualified Event (see the [“Qualified Events for the retiree medical and dental plan options”](#) section in “Chapter 1: Eligibility, Enrollment, and More”) 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 as described in more detail below. 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 annual deductible and annual out-of-pocket maximum are adjusted to your new coverage level for that plan year. 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 for your new coverage level, regardless of your effective date of coverage. Expenses incurred before the effective date of the increased coverage level by individuals added to your coverage do not count toward the adjusted annual deductible or annual out-of-pocket maximum for your increased coverage level, even if these individuals had coverage separately under the HSA-Based Medical Plan before being added to your coverage.

When your coverage level decreases due to a Qualified Event, your annual deductible and annual out-of-pocket maximum are adjusted to the new coverage level for that plan year, but are not prorated. You are required to meet the full year annual deductible and annual out-of-pocket maximum for your new coverage level, regardless of your effective date of coverage. Additionally, only amounts that applied to the current year’s annual deductible and annual out-of-pocket maximum under the previous coverage level that were incurred by individuals who continue to be covered under your decreased coverage

level will be applied to the adjusted annual deductible and annual out-of-pocket maximum for the plan year. Charges incurred by any other individual (even if applied to the annual deductible or annual out-of-pocket maximum for your previous coverage level) do not count toward the adjusted annual deductible and annual out-of-pocket maximum for your decreased coverage level. For example, if you had you + spouse + children coverage and drop coverage for your spouse, the charges previously incurred by your spouse will not count toward the adjusted annual deductible and annual out-of-pocket maximum for the plan year even if those same charges were previously applied to the annual deductible or annual out-of-pocket maximum when your spouse was covered.

COBRA enrollment

If a former spouse or a dependent is eligible for and elects to enroll midyear in the retiree HSA-Based Medical Plan under COBRA continuation coverage, the applicable annual deductible and annual out-of-pocket maximum amounts are not prorated; he or she is required to meet the full year annual deductible and annual out-of-pocket maximum regardless of the effective date of COBRA continuation coverage during the year. For example, if the COBRA continuation coverage is effective July 1 at the you only coverage level, the ex-spouse or dependent would be required to meet the full \$3,000 in-network annual deductible, and the \$5,000 in-network annual out-of-pocket maximum would apply.

Any charges that were incurred by your ex-spouse or dependent and applied toward the current year annual deductible and annual out-of-pocket maximum (under your retiree HSA-Based Medical Plan coverage) will count toward the COBRA participant’s new individual annual deductible or annual out-of-pocket maximum under his or her HSA-Based Medical Plan COBRA continuation coverage for the same plan year.

Lifetime benefits accruals for infertility treatment and transplant services will transfer and apply to the COBRA participant’s coverage.

If you are rehired as an employee

When you are rehired as an active employee, your HSA-Based Medical Plan coverage under the Wells Fargo & Company Retiree Plan terminates the day immediately preceding the day of your rehire.

Refer to the *Benefits Book* for information about eligibility, enrollment, and electing medical coverage under the Wells Fargo & Company Health Plan as a benefits-eligible employee.

The claims administrator will continue to process any eligible medical claims incurred before the termination of coverage and filed within 12 months of the date of service.

When you become ineligible for coverage or drop coverage

If you become ineligible for coverage or if you voluntarily drop your coverage, your coverage ends at the end of the month. If you elect another medical benefit option under the Wells Fargo & Company Retiree Plan at any time or otherwise elect to drop your HSA-Based Medical Plan coverage, your coverage under the HSA-Based Medical Plan will end. The claims administrator will continue to process claims for eligible expenses incurred prior to the termination of coverage and filed within the required claims filing time period.

If your dependent becomes ineligible for coverage, his or her coverage ends at the end of the month unless he or she elects COBRA continuation coverage for the HSA-Based Medical Plan during his or her initial COBRA enrollment period. For more

information on general requirements for COBRA continuation coverage, see “[Appendix E: Continuing Coverage Under COBRA](#).” For more information on enrollment in the HSA-Based Medical Plan under COBRA continuation coverage, see the “COBRA enrollment” section on this page.

When COBRA continuation coverage ends, the claims administrator will continue to process claims for eligible expenses incurred prior to the termination of coverage and filed within the required claims filing time period.

Note: Coverage for a deceased individual ends on the date of death and retiree premiums are due for the month in which the participant passes away. Premiums due for the month are not prorated.

Health Savings Account (HSA)-Based Medical Plan: Annual deductible and annual out-of-pocket maximum

These amounts apply to individuals enrolled in the HSA-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 2-85 for information about how prescription drugs are covered.

Annual deductible	Your annual deductible responsibility	
	Includes eligible prescription drugs	
Coverage level	In-network providers	Out-of-network providers
You	\$3,000	\$6,000
You + spouse*	\$4,500	\$9,000
You + children	\$4,500	\$9,000
You + spouse* + children	\$6,000	\$12,000

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

Annual out-of-pocket maximum	Your annual out-of-pocket maximum responsibility	
	Includes deductible and eligible prescription drugs	
Coverage level	In-network providers	Out-of-network providers
You	\$5,000	\$10,000
You + spouse*	\$7,500	\$15,000
You + children	\$7,500	\$15,000
You + spouse* + children	\$10,000	\$20,000

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

Programs, tools, and resources to help you manage your health

UnitedHealthcare, the claims administrator for the retiree HRA-Based Medical Plan and retiree HSA-Based Medical Plan, offers additional programs, tools, and resources to help retirees and covered dependents better manage their health and make healthier lifestyle choices.

These resources are voluntary, confidential, and available at no additional cost to retirees and covered dependents.

UnitedHealthcare and Express Scripts 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 be invited to participate in one or more of these programs, or you can contact your claims administrator for more information about program participation. These services are offered at no cost to participants.

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. Call the UnitedHealthcare NurseLine at 1-800-842-9722.

Web-based tools and resources

Web-based tools and resources may be available through myuhc.com.

Autism Spectrum Disorder (ASD) Support

ASD Support provides a single point of contact to help members connect with available programs and resources, and works closely with our other clinical and customer services teams to ensure families impacted by autism have access to the right care and information. Autism-focused, licensed behavioral health clinicians provide support and act as consultants to the interdisciplinary team surrounding the member, helping them navigate and address the unique challenges facing families with an autistic child. The result is enhancement of the member's overall experience, effective use of benefits, and access to coordinated and appropriate care.

Behavioral Health Resources

The medical plans offer behavioral health case manager support. The case managers are licensed mental health professionals whose goals are to help you take control of your health care and improve your quality of life. They are there to help provide support for you and your family.

Your case manager will work with you to:

- Help you and your family understand your condition
- Develop a personalized plan to help you reach your behavioral health goals
- Identify and help you overcome hurdles that may be keeping you from reaching your goals

- Connect with helpful community and online resources
- Review and coordinate services you get from local and community providers
- Help ensure you're getting all the benefits available to you under your health plan
- Help you become your own advocate
- Help you to work with a dedicated and specialized team of resources to meet your needs

On your first call together, your case manager will ask you questions to better understand what you're dealing with, where you are in your treatment, and what you hope to achieve. After that call, the case manager will begin working with you to make a plan to help you meet your goals. He or she will stay in touch with you as you work toward those goals.

If you'd like to learn more about our Behavioral Health Case Management programs contact your claims administrator and ask to speak to a Behavioral Health Case Manager.

Bariatric surgery support

The resource provides clinical support before and after weight loss surgery.

Condition management

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

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

Maternity support

If you are pregnant, you can receive educational information and tips for a healthy pregnancy. Contact United Healthcare as early in your pregnancy as possible to participate in the program.

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.

Cancer support

Cancer management programs provide guidance and help ensure coordination of resources for your treatment.

Health education materials

Each of the claims administrators also provides tools and educational materials to help you stay healthy. These services can be accessed by visiting the claims administrator's website or by calling the member services number on your card.

2nd.MD second medical opinion

Second medical opinion, available through 2nd.MD, is a service that provides access to personalized second opinions, by video or phone, at no additional charge. Access is provided through convenient consultations with leading medical experts within three to five days through 2nd.MD. This additional medical information may help you make more informed decisions about your care.*

*It is educational in nature and does not diagnose, treat, or prescribe treatment of medical conditions.

Real Appeal program

Real Appeal is a digital 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 to retirees, 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. Real Appeal is not available to individuals enrolled in the Kaiser medical plans or Medicare Advantage plans.

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. For additional information or to enroll, visit realappeal.com or call Real Appeal at 1-844-924-7325. Adult dependents should call Rally Support at 1-877-543-4294 to enroll.

Medical specialty drugs administered by a medical provider

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 injectables, and any drug that must be administered by a provider. This section applies when a provider orders the drug and a medical provider administers it to you in a medical setting. Specialty drugs that you can administer to yourself (or a caregiver may administer to you) are not covered under the medical benefit. Specialty drugs you get from a retail or mail order pharmacy are also not covered under your medical benefit.

Precertification is required for certain medically administered specialty drugs to help make sure proper use and guidelines for these drugs are followed. Your provider will submit clinical information, which will be reviewed for decision. UnitedHealthcare will give the results of its decision to both you and your provider by letter.

For a list of medically administered specialty drugs that need precertification, please call the phone number on the back of your medical plan Identification Card. The precertification list is reviewed and updated from time to time. Including a specialty drug on the list does not guarantee coverage under your plan. Your provider may check with UnitedHealthcare to verify specialty drug coverage, and to find out which drugs are covered under this section and if precertification is required.

Orthopedic treatment decision support

If you complete Orthopedic Treatment Decision Support ("Treatment Decision Support" or "TDS") and use a designated facility for eligible spine (back) and joint (knees and hips) inpatient surgery, 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% (HRA-Based Medical Plan) or 90% (HSA-Based Medical Plan) of eligible expenses after you satisfy the annual deductible. **There is no coverage for inpatient services received from out-of-network providers. The plan pays 50% of eligible expenses after you satisfy the annual deductible for outpatient services received from out-of-network providers.**

Contact UnitedHealthcare to see if this program is right for you before scheduling your surgery. Participants may receive a phone call from a nurse to discuss and share important health care information related to the participant's spine (back) and joint (knees and hips) inpatient surgery.

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), 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 *Retiree Benefits Book*.

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

UnitedHealthcare

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

Medically necessary — health care services that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare’s sole discretion. The services must be all of the following:

- In accordance with Generally Accepted Standards of Medical Practice.

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

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

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

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

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

- Air ambulance — non-emergent
- Approved fetal interventions
- Arthroplasty

- Arthroscopy (shoulder, elbow, hip, knee)
- Bariatric surgery
- Bone growth stimulation
- BRCA testing (genetic testing for breast cancer susceptibility)
- Cancer treatment services received through the Cancer Resource Services program
- Cardiac imaging or stress tests
- Cardiac rehabilitation services
- Cartilage implants
- Cerebral seizure monitoring inpatient video (electroencephalogram [EEG]) when inpatient
- Certain spine (back) and joint (knees and hips) procedures
- Chemotherapy services – specifically injectable Rx rendered by an MD that require PA
- Clinical trials
- Cochlear implants and other auditory implants
- Congenital heart disease services under the Congenital Heart Disease (CHD) services program
- Congenital heart disease surgical interventions
- CT or CAT scans
- Dental and oral surgery, including but not limited to services that are accident-related for the treatment of injury to sound and healthy natural teeth; temporomandibular joint (TMJ) surgical procedures; and orthognathic surgery
- Diagnostic cardiac catheterization
- Dialysis (outpatient)
- Durable medical equipment that costs \$1,000 or more (either purchase or cumulative rental of a single item) and certain supplies, prosthetics, or devices that cost \$1,000 or more (either purchase or cumulative rental of a single item)
- Electrophysiology implant
- Extended skilled nursing services
- Fetal echocardiograms
- Foot surgery
- Functional endoscopic sinus surgery (FESS)
- Genetic and molecular testing
- GID Surgical OP/IP procedures
- Heart catheterization
- Home health care services
- Home infusion therapy services
- Hospice care
- Hysterectomy
- Infertility and fertility services and treatments
- Inflammatory injectable medications
- Injectable medications (a drug capable of being injected intravenously through an intravenous infusion, subcutaneously, or intramuscularly)
- Inpatient hospital, inpatient treatment, or other inpatient medical facility admissions (such as residential treatment or structured outpatient care, which are considered forms of inpatient care), within 24 hours of emergency inpatient admission, for medical or mental health and substance abuse inpatient admissions
- Intensity modulated radiation therapy
- Interventional cardiac catheterizations
- Maternity services if stay exceeds the 48-hour or 96-hour guidelines (including stays for a newborn that continue after the mother has been discharged)
- Medical specialty drugs administered by a medical provider (for more information see the [“Medical specialty drugs administered by a medical provider”](#) section on page 2-20)
- MR-guided focused ultrasound
- MRI or MRA scans
- Non-emergent ambulance services
- Nuclear medicine services
- Oncology services received through the Cancer Resource Services program
- Out-of-network outpatient surgery
- Outpatient sleep studies, including associate lab and x-ray services
- PET scans
- Prescription drugs that require administration under the direct supervision of a health care professional
- Prosthetic device that costs \$1,000 or more
- Proton beam therapy
- Reconstructive surgery or procedures
- Sinuplasty
- Skilled nursing facility stays
- Sleep apnea procedures and surgeries
- Spine surgeries
- Temporomandibular joint (TMJ) disorder surgery
- Therapeutics (outpatient)
 - Dialysis
 - IMRT
 - MR-guided focused ultrasound
 - IV infusion
 - Radiation oncology
- Transplant services
- Vagus nerve stimulation

- Vein procedures
- Ventricular assist devices

You are required to obtain pre-service authorization for the services listed below before receiving these services from an out-of-network provider. Failure to follow the UnitedHealthcare pre-service authorization procedures for the following out-of-network services will result in a 20% reduction of the amount otherwise payable for eligible services:

- Autism services and therapies
- 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), 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 *Retiree 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, evaluating, diagnosing, or treating a sickness, an injury, mental illness, substance abuse, or their respective 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 with 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.

You may obtain copies of the claims administrator's reimbursement policy for yourself or to share with your non-network physician or provider. These policies are available on the claims administrator's website or by calling the telephone number on your ID card.

UnitedHealthcare administered medical plans

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

- According to UnitedHealthcare's reimbursement policy guidelines. These policy guidelines are developed, in UnitedHealthcare's sole discretion, in accordance with one or more of the following methodologies:
 - As indicated in the most recent edition of the *Current Procedural Terminology* (CPT), a publication of the American Medical Association, or the *Centers for Medicare and Medicaid Services* (CMS)
 - As reported by generally recognized professionals or publications
 - As used for Medicare
 - As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts

Regardless of provider network status, you will typically be required to pay a portion of the maximum allowed amount for covered services to the extent you have not met your deductible or have a copayment or coinsurance.

When covered health services are received from in-network providers, eligible expenses are UnitedHealthcare's contracted fees with that provider. Your in-network provider may not bill you for amounts above the eligible expense for covered health services (that is the difference between the contracted rate and the billed charge). You are responsible for any charges associated with services the plan does not cover. Charges for services not covered by the plan do not apply toward the annual deductible or annual out-of-pocket maximum.

If you are enrolled in the HRA-Based Medical Plan or the HSA-Based Medical Plan, when covered health services are received from out-of-network providers, your out-of-network provider may bill you for the amounts above the eligible expense, as determined by UnitedHealthcare; including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You are also responsible for any charges associated with services the plan does not cover. These amounts above the eligible expense do not apply toward the applicable annual deductible or out-of-pocket maximums.

- For emergency health services, UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* or a third party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an emergency health service. If the methodology currently in use becomes no longer available, UnitedHealthcare will use a comparable methodology. UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at myuhc.com for information regarding the vendor that provides the applicable methodology.
- *Eligible expenses under the Shared Savings Program.*

The Shared Savings Program is a program through which UnitedHealthcare may obtain a discount to an out-of-network provider's billed charge. Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to out-of-network providers who have agreed to discounted costs for services (in comparison to the provider's typically billed charge for the particular service). This discount is usually based on a schedule previously agreed to by the out-of-network provider. When this happens, you may experience lower out-of-pocket amounts. The plan's annual deductible and coinsurance still apply to the reduced charge.

Sometimes plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case, the out-of-network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens, you should call the number on your ID Card. Shared Savings Program providers are not in-network providers and are not credentialed by UnitedHealthcare.

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 on page 2-23 for more information.)

The services and cost-sharing amounts on the following pages are subject to the limitations, exclusions, and procedures described in this chapter. When more than one definition or provision applies to a service, the most restrictive applies and exclusions and any other stated limits take precedence over general benefits descriptions.

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 (except for in-network preventive care). The annual deductible is referred to as “deductible” in the [cost-sharing tables](#) starting on page 2-26. Unless otherwise noted, the in-network deductible must be met separately for services received from an in-network provider and the out-of-network deductible must be met separately for services from an out-of-network provider. For more information about the deductible, see the “[Important terms](#)” section on page 2-7.

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

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	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 26 visits per plan year, in-network and out-of-network services combined.	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 26 visits per plan year, in-network and out-of-network services combined.	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 26 visits per plan year, in-network and out-of-network services combined.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay 30% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.

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. Benefits are 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 2-77.

Notes

If a service is performed by a chiropractor, it will be applied to the 26-visit chiropractic benefit limit.

Ambulance

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the in-network deductible.	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.

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 10% of eligible covered expenses after you satisfy the in-network deductible.

The medical plans cover

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

- Ambulance service from the place of emergency departure to the nearest local hospital required for stabilization and initiation of treatment as provided under the direction of a physician in an emergency situation.
- Air ambulance to the nearest facility qualified to give the required treatment, as determined by the claims administrator, when ground ambulance transportation is not medically appropriate because of the distance involved or because the covered patient has an unstable condition requiring medical supervision and rapid transport. This would include transportation, if needed in a foreign country, to transport to the nearest facility qualified to treat the patient as determined by the claims administrator.

Note: In cases where pre-authorization is not obtained or where the claims administrator has determined that air transport is not covered (for example, because it is not medically necessary) no amount will be allowed for air transport and you will be responsible for any air ambulance charges. This could occur, for example, where air transport is directed to a facility other than the facility approved by the claims administrator.

- Ambulance transport to a hospital at the next level of acute care services, for example, a skilled nursing facility or rehabilitation facility (does not include transport to custodial care or facility, or transport to a residence).
- Ambulance transport from a skilled nursing facility or rehabilitation facility to another facility or hospital for tests or diagnosis when such tests or diagnostics cannot be rendered at the initial facility.

Not covered

- Air ambulance services that are not approved by the claims administrator.
- 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 2-77.

Notes

Non-emergent ambulance services are subject to pre-service authorization (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 for more information).

Autism coverage

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

The medical plans cover Applied Behavioral Analysis (ABA) Intensive Behavioral Therapy (IBT) for covered participants and dependents with diagnosed 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 2-20 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 or 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

Covered health services include enhanced autism spectrum disorder services that are focused on behavioral intervention, that are habilitative in nature, and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome.

Each case will be reviewed, the diagnosis validated, and the treatment plan will be evaluated for appropriateness, based on the level of care standards of the claims administrator.

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 IBT previously noted, even if the supplies or equipment are recommended or prescribed by a physician

Also, refer to the [“Exclusions”](#) section starting on page 2-77.

Notes

For services coded as an office visit (excluding ABA services), refer to the [“Office visit — outpatient mental health and substance abuse \(in-person or virtual\)”](#) section on page 2-59.

Bariatric services

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible if services are received at a designated facility.	No coverage.	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible if services are received at a designated facility.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible if services are received at a designated facility.	No coverage.

The medical plans cover

Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 for more information). If pre-service authorization is received, the medical plans cover gastric bypass or lap band surgery if specific criteria are met. Bariatric surgery, also known as weight loss surgery, refers to the various surgical procedures performed to treat people living with morbid or extreme obesity. It may be an effective treatment for weight loss for those who have not experienced long-term weight loss success through other means.

For the 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. For more information on inpatient hospital stays, see the [“Hospital inpatient services \(inpatient hospital, inpatient treatment, or other inpatient medical facility admissions\)”](#) section starting on page 2-48. For more information on outpatient surgery, see the [“Outpatient surgery, diagnostic, and therapeutic services”](#) section starting on page 2-60.

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, unless medically necessary to treat a medical condition when the claims administrator's medical criteria are met

- Food, food substitutes, or food supplements of any kind (such as diabetic, low-fat, or low-cholesterol)
- Megavitamin and nutrition-based therapy
- Oral vitamins and oral minerals
- Removal of excess skin or fat, or both, when the procedure does not meet the claims administrator's medical criteria

Also, refer to the [“Exclusions”](#) section starting on page 2-77.

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 in-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 \(in-person or virtual\)”](#) section on page 2-59 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 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 2-75 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.

Chiropractic care and spinal manipulation

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	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 26 visits per plan year, in-network and out-of-network services combined.	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 26 visits per plan year, in-network and out-of-network services combined.	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 26 visits per plan year, in-network and out-of-network services combined.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.	You pay 30% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 26 visits per plan year, in-network and out-of-network services combined.

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 2-77.

Convenience care (in a retail setting)

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

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

Note: A convenience clinic is not an urgent care center. For information on benefits related to urgent care, see the "[Urgent Care Clinics](#)" section on page 2-76.

Not covered

Refer to the "[Exclusions](#)" section starting on page 2-77.

Dental care

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

Hospital-related dental services

Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 for more information). If pre-service authorization is received, the medical plans cover certain hospital services (see the [“Covered health services definition”](#) section on page 2-23). Coverage is limited to charges incurred by a covered person who:

- Is a child under age five
- Is a child between the ages of five and 12 and where either of the following conditions is met:
 - Care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful
 - Extensive amounts of restorative care, exceeding four appointments, are required
- Is severely disabled
- Has one of the conditions listed below, requiring hospitalization or general anesthesia for dental care treatment:
 - Respiratory illnesses
 - Cardiac conditions
 - Bleeding disorders
 - Severe risk of compromised airway
 - The need for extensive procedures that prevent an oral surgeon from providing general anesthesia in the office setting, regardless of age
 - Psychological barriers to receiving dental care, regardless of age

The coverage is limited to facility and anesthesia charges. Oral surgeon or dentist professional fees are not covered. Covered health services are determined based on established medical policies, which are subject to periodic review and modification by the claims administrator's medical directors.

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

- Prepare for transplant
- Initiate immunosuppressives
- Diagnose cancer
- Directly treat current instance of cancer

Accidental dental services

Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 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, not for cracked or broken teeth that result from biting or chewing.

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 2-20 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 2-20 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 2-20 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 2-20 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 health services do not include fixed or removable appliances that involve movement or repositioning of the teeth or operative restoration of the teeth or prosthetics.
- Orthognathic surgery is covered for the treatment of TMJ and craniomandibular disorder, as determined by the medical policy criteria of the claims administrator.

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 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 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 2-77.

Durable medical equipment, supplies, and prosthetics

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

Pre-service authorization is required before obtaining any single item that costs \$1,000 or more (purchase price or cumulative rental of a single item). See the [“Pre-service authorization requirements”](#) section starting on page 2-20.

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

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

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

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

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

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

Benefits are provided for the replacement of each type of prosthetic device when it can no longer be repaired to have it function at its original specifications. This will not be more often than every three years.

Covered durable medical equipment includes the following when the claims administrator's medical criteria are met:

- Appliances for snoring when provided as a part of treatment for documented obstructive sleep apnea
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces
- Braces to treat curvature of the spine
- Compression stockings or compression sleeves when used for care related to the diagnosis of lymphedema or for edema in pregnancy
- Cranial bands and helmets for children up to age 18 months old
- Delivery pumps for tube feeding
- Insulin pumps, pump supplies, and glucose monitors
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions
- Oxygen concentrator units and equipment rental to administer oxygen
- Shoe or foot orthotics
- Speech devices
- Standard hospital bed

- Wheelchair (standard, electric, or custom) when ordered by a physician and medically necessary
- Wigs up to \$500 per calendar year as deemed medically necessary by the claims administrator

Covered supplies include:

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

Not covered

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

- Treatments for androgenetic alopecia, which is the most common form of hair loss encompassing conditions such as male pattern baldness or hair thinning
- Appliances for snoring, except as previously noted for sleep apnea
- The cost of an extended warranty or a service contract
- Cranial bands, banding, remolding, and helmets for individuals 18 months and older
- Dental braces
- Devices used specifically as safety items or to affect performance in sports-related activities
- Diets for weight control or treatment of obesity (including liquid diets or food)
- Duplicate or similar items
- Charges for purchase or replacement of eyeglasses, contact lenses, or other optical devices or professional services including to fit or supply them, except as specifically described in this SPD
- Food, food substitutes, or food supplements (such as diabetic, low-fat, low-cholesterol, or infant formula) unless specifically noted in this SPD
- Hearing aids or devices, whether internal, external, or implantable, and related fitting or adjustment, except as specified in this SPD (see the “[Hearing aids](#)” table on page 2-43 for more information)
- 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
- Items that can be obtained without a prescription or physician’s order
- Items that are primarily educational in nature or for hygiene, vocation, comfort, convenience, or recreation
- Labor and related charges for repair of any covered items that are more than the cost of replacement by an approved vendor
- Megavitamin and nutrition-based therapy
- Modifications to the structure of the home, including but not limited to wiring, plumbing, or charges for installation of equipment
- Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs (see the “[Prescription drug benefit](#)” section starting on page 2-85 for information on diabetic supplies)
- Oral or dental prosthesis except as previously noted within the “[Dental care](#)” section or as otherwise deemed medically necessary by the claims administrator
- Other equipment and supplies, including but not limited to assistive devices that the claims administrator determines are not eligible for coverage
- Prescribed or nonprescribed medical supplies and disposable supplies, including elastic stockings, ace bandages, gauze, and dressings, except as noted above
- Rental equipment while the covered person’s owned equipment is being repaired, beyond one-month rental of equipment
- Replacement or repair of any covered items, if the items are:
 - Damaged or destroyed by misuse, abuse, or carelessness
 - Lost
 - Stolen
- Sales tax, mailing and delivery, and service call charges
- Services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including but not limited to:
 - Air conditioners
 - Air purifiers
 - Computers and related equipment
 - Dehumidifiers
 - Exercise equipment
 - Feeding and bath chairs
 - Food or weight scales
 - Heat or cold appliances
 - Hot tubs or whirlpools
 - Hypoallergenic mattresses
 - Incontinence pads or pants
 - Pillows
 - Waterbeds
 - Water purifiers

- Tubings, nasal cannulas, connectors, and masks, except when used with durable medical equipment
- Vehicle, car, or van modifications, including but not limited to hand brakes, hydraulic lifts, and car carriers

Also, refer to the “[Exclusions](#)” section starting on page 2-77.

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).

Emergency care

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses for emergency care after you satisfy the in-network deductible.	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the in-network deductible.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 10% of eligible covered expenses for emergency care after you satisfy the in-network deductible.

The medical plans cover

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

For ambulance or air ambulance services, see the “[Ambulance](#)” section on page 2-27.

Not covered

- Nonemergency use of the emergency room, as determined by the claims administrator unless referred to the emergency room by your claims administrator’s nurseline. This would include follow-up care done in an emergency room (for example, wound checks, suture removal, etc.).
- Nonemergency coverage while abroad or overseas.

Also, refer to the “[Exclusions](#)” section starting on page 2-77.

Extended skilled nursing care

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	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.	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.	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.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with home health care visits, in-network and out-of-network services combined.	You pay 30% 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.

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 a 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 2-20).

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 2-85 for coverage information and pre-service authorization requirements and instructions.

Not covered

- Nursing care that does not require the education, training, and technical skills of an RN or LPN.
- Nursing care provided for skilled observation.
- Nursing care provided while the covered person is an inpatient in a hospital or health care facility.
- Nursing care to administer routine maintenance medications or oral medications, except where law requires an RN or LPN to administer medicines.
- Custodial care for daily life activities including but not limited to:
 - Transportation
 - Meal preparation
 - Vital sign charting
 - Companionship activities
 - Bathing
 - Feeding
 - Personal grooming
 - Dressing
 - Toileting
 - Getting in or out of bed or a chair
- Services that can be safely and effectively performed by a nonmedical person or self-administered without the direct supervision of a licensed nurse. The unavailability of a person to provide an unskilled service does not allow for coverage for a nurse to provide unskilled services.
- Private-duty nursing.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the “[Prescription drug benefit](#)” section starting on page 2-85 for coverage information.

Also, refer to the “[Exclusions](#)” section starting on page 2-77.

Gender reassignment

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.	Not covered.	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.

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	Not covered.

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 2-20 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 2-20 for the contact information.

Generally, covered expenses include:

- Outpatient office visits (see the [“Office visit — primary care physician \(PCP\) \(in-person or virtual\)”](#) section on page 2-57 and the [“Office visit — outpatient mental health and substance abuse \(in-person or virtual\)”](#) section on page 2-59 for more information).
- Pre- and postsurgical hormone therapy covered under the pharmacy benefit. Refer to the [“Prescription drug benefit”](#) section starting on page 2-85 for coverage information and any pre-service authorization instructions.
- Facial feminization surgery (male to female), including but not limited to facial bone reduction, face “lift,” facial hair removal, and certain facial plastic procedures.
- Hair removal (male to female) for skin grafting related to genital reconstruction.
- Hair transplant coverage for male to female gender reassignment.

- Genital surgery 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 2-20 for more information).
- Voice modification surgery.
- Voice therapy.

Conditions for coverage

To receive benefits, the patient must:

- Be at least 18 years of age
- Have undergone 12 months of successful, continuous, full-time, real-life experience
- If required by the mental health professional, have participated regularly in psychotherapy throughout the real-life experience
- Show a demonstrable knowledge of the cost, required lengths of hospitalizations, and likely complications
- Be aware of postsurgical rehabilitation requirements of various surgical approaches
- Undergo psychotherapy both before and after the surgery

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.

Also, refer to the “[Exclusions](#)” section starting on page 2-77.

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 2-75 for information about covered travel expenses related to gender reassignment surgery.

Hearing aids

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

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

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

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

Post cochlear implant aural therapy is covered. Check with your claims administrator regarding any limitations.

Not covered

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

Also, refer to the "[Exclusions](#)" section starting on page 2-77.

Home health care

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	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 extended skilled nursing care, in-network and out-of-network services combined.	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 extended skilled nursing care, in-network and out-of-network services combined.	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 extended skilled nursing care, in-network and out-of-network services combined.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care, in-network and out-of-network services combined.	You pay 30% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 visits per plan year combined with extended skilled nursing care, in-network and out-of-network services combined.

The medical plans cover

Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 for more information). If pre-service authorization is received, the medical plans cover certain home health care services limited to 100 visits per plan year by a home health care professional (the 100-visit maximum is for combined in-network and out-of-network services) combined with extended skilled nursing care. One visit is equal to four consecutive hours in a 24-hour period.

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

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

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

Note: For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home, refer to the [“Prescription drug benefit”](#) section starting on page 2-85 for coverage information and pre-service authorization requirements and instructions.

Not covered

- Services provided by a home health agency when a primary caregiver could provide those same services in the home. Home health services are not provided as a substitute for a primary caregiver in the home or as a relief (respite) for a primary caregiver in the home.
- Services provided by a primary caregiver in the home.
- Custodial or nonskilled care, maintenance care, or home health care delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair. Custodial or maintenance care includes but is not limited to help getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs. This type of care is primarily required to meet the patient's personal needs or maintain a level of function, as opposed to improving that function to allow for a more independent existence. The care does not require continued administration by trained medical personnel to be delivered safely and effectively.
- Services of a nonmedical nature.
- Services that can be safely and effectively performed by a nonmedical person or self-administered without the direct supervision of a licensed nurse. The unavailability of a person to provide an unskilled service does not allow for coverage for a home health care provider to provide unskilled services.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the "[Prescription drug benefit](#)" section starting on page 2-85 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 on page 2-39 for more information).

Also, refer to the "[Exclusions](#)" section starting on page 2-77.

Homeopathic and naturopathic services

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	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 20 visits per plan year, in-network and out-of-network services combined.	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 20 visits per plan year, in-network and out-of-network services combined.	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 20 visits per plan year, in-network and out-of-network services combined.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 20 visits per plan year, in-network and out-of-network services combined.	You pay 30% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 20 visits per plan year, in-network and out-of-network services combined.

The medical plans cover

The medical plans cover homeopathic and naturopathic office visits with a state-licensed homeopathic or naturopathic 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 and naturopathic providers are not licensed in all states; if you receive services from an unlicensed provider, you are responsible for all charges.

Not covered

- Charges in addition to the office visit charge, including but not limited to charges for equipment, supplies, or supplements
- Charges for services received from a non-licensed naturopathic or homeopathic provider or a provider licensed outside the state where services are rendered

Also, refer to the [“Exclusions”](#) section starting on page 2-77.

Hospice care

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 for more information). If pre-service authorization is received, the medical plans cover hospice care that is prescribed by a physician. Hospice care is an integrated program that provides supportive care to terminally ill individuals and their families. This care may be provided instead of a hospital confinement when a covered individual is terminally ill and has less than six months to live. Benefits are available when hospice care is received from a licensed hospice agency for the following services:

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

Not covered

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

Also, refer to the [“Exclusions”](#) section starting on page 2-77.

Hospital inpatient services (inpatient hospital, inpatient treatment, or other inpatient medical facility admissions)

Plan	What you pay		
	In-network providers ¹	Out-of-network providers ¹	Out of Area ^{1,2} coverage
HRA-Based Medical Plan	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.	Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses after you satisfy the deductible.	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.

1. If you need eligible spine (back) and joint (knees and hips) procedures, refer to the [“Orthopedic treatment decision support”](#) section on page 2-20. There is no out-of-network coverage for these services.

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

Plan	What you pay	
	In-network providers*	Out-of-network providers*
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

* If you need eligible spine (back) and joint (knees and hips) procedures, refer to the [“Orthopedic treatment decision support”](#) section on page 2-20. There is no out-of-network coverage for these services.

The medical plans cover

Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 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 a 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 2-77.

Notes

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, the claims administrator will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.
- Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.

When more than one diagnostic procedure is performed within the same diagnostic family (for example, scopic procedures, x-rays, CT, or MRI) during the same session, one procedure will be considered at 100% of the eligible expense and the other procedures will be considered at 50% of the eligible expense.

Orthopedic Treatment Decision Support

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

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

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	Available HRA dollars pay 100%, then you pay 20% of eligible covered expenses after you satisfy the deductible. Infertility treatment is limited to a lifetime maximum benefit of \$10,000, in-network and out-of-network services combined.	Available HRA dollars pay 100%, then you pay 40% of eligible covered expenses after you satisfy the deductible. Infertility treatment is limited to a lifetime maximum benefit of \$10,000, in-network and out-of-network services combined.	Available HRA dollars pay 100%, then you pay 20% of eligible covered expenses after you satisfy the deductible. Infertility treatment is limited to a lifetime maximum benefit of \$10,000, in-network and out-of-network services combined.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible. Infertility treatment is limited to a lifetime maximum benefit of \$10,000, in-network and out-of-network services combined.	You pay 30% of eligible covered expenses after you satisfy the deductible. Infertility treatment is limited to a lifetime maximum benefit of \$10,000, in-network and out-of-network services combined.

The medical plans cover

Pre-service authorization is required (see the “[Pre-service authorization requirements](#)” section starting on page 2-20 for more information). If pre-service authorization is received, the medical plans cover certain professional services (including artificial insemination), services for the diagnosis, and treatment for correction of underlying conditions of infertility. Benefits for covered health services related to infertility are limited to a lifetime maximum benefit paid by the retiree medical plan of \$10,000 (in-network and out-of-network services combined) for diagnosis and treatment for correction of underlying conditions. You must be diagnosed with infertility, as defined by your claims administrator, to be eligible for artificial insemination.

Not covered

- Infertility prescription drugs.
- In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), and related charges are specifically excluded from coverage. Services and prescription drugs for or related to assisted reproductive technology (ART) procedures, actual or attended impregnation or fertilization (for example, embryo implantation or transfer, IVF), including but not limited to GIFT and ZIFT.
- Health services and associated expenses for infertility treatments, except artificial insemination.
- A surrogate's (or gestational carrier's) pregnancy on your behalf and related obstetric and maternity benefits.

- Reversal of voluntary sterilization and any related charges.
- Treatment of infertility after reversal of voluntary sterilization and any related charges.
- Fees or payment to a donor for sperm or ovum donations.
- Fees for maintenance or storage of sperm, ovum, or frozen embryos.
- Services and prescription drugs for or related to gender selection services.
- Services exceeding the lifetime maximum for this benefit.

Also, refer to the “[Exclusions](#)” section starting on page 2-77.

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 2-75 for information about covered travel expenses related to infertility and fertility services and treatment.

Maternity care

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	See the “ Notes ” section on this page.	Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses after you satisfy the deductible.	See the “ Notes ” section on this page.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

The medical plans cover all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The medical plans will pay benefits for the covered mother and the newborn (provided that you add the child to your medical coverage through Wells Fargo within 60 days of the date of birth; refer to “[Chapter 1: Eligibility, Enrollment, and More](#)”) for an inpatient stay while both are in the hospital, as follows:

- 48 hours from time of delivery for the mother and newborn child following a normal delivery
- 96 hours from time of delivery for the mother and newborn child following a cesarean section delivery

You do not need authorization from the claims administrator if your provider prescribes a hospital stay of this length. However, if your provider determines that a longer stay is required for either the mother or the baby, you must notify your claims administrator as soon as reasonably possible. If you don’t notify the claims administrator that the inpatient stay will be extended, benefits for the extended stay may be reduced.

If the mother agrees, the attending provider may discharge the mother, the newborn child, or both, earlier than these minimum stays.

Refer to the “[Preventive care services \(eligible preventive care services\)](#)” section on page 2-64 for information on newborn immunization and routine care. You must call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557) 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.

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 2-77.

Notes

*HRA-Based Medical Plan
(in-network and Out of Area coverage only):*

You will pay 20% coinsurance after you satisfy the annual deductible for the initial visit to a PCP or OB/GYN. 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% until HRA dollars are exhausted while you are in the deductible phase.
 - 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 20% coinsurance for the remaining portion of the global bill eligible expense.
 - Some services may be nonroutine or not part of the global bill; you will pay the applicable coinsurance for these services.

- If your provider does not submit a global bill and is not required to by the claims administrator:
 - You will pay 20% coinsurance after you satisfy the annual deductible for the initial office visit, and then office visits with a PCP or OB/GYN related to this pregnancy that are billed with a primary diagnosis code of pregnancy or maternity will be covered at 100% of the eligible expense for the office visit charge.
 - All other maternity-related covered health services including lab services, specialist visits, and delivery are subject to the annual deductible.
 - 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 expenses until the annual deductible is met.

Available HRA dollars will be applied to your deductible responsibility and your coinsurance. HRA dollars cannot be used for prescription drug copays.

- Hospital inpatient services are subject to the applicable annual deductible and coinsurance. See the “[Hospital inpatient services \(inpatient hospital, inpatient treatment, or other inpatient medical facility admissions\)](#)” section starting on page 2-48 for more information.
- Be aware that your in-network provider may enlist the services of an out-of-network provider and those services may be billed separately and will be subject to the out-of-network annual deductible and cost-sharing.

When services are received from an out-of-network provider, you pay the amount above the allowed amount in addition to any applicable deductible or 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 on page 2-64 for coverage of these services.

HSA-Based Medical Plan (in-network 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 10% coinsurance for covered health services without a primary diagnosis of pregnancy or maternity.
- Hospital inpatient services are subject to the applicable annual deductible and coinsurance. See the “[Hospital inpatient services \(inpatient hospital, inpatient treatment, or other inpatient medical facility admissions\)](#)” section starting on page 2-48 for more information.
- Be aware that your in-network provider may enlist the services of an out-of-network provider and those services may be billed separately and will be subject to the out-of-network annual deductible and cost-sharing.

When 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 on page 2-64 for coverage of these services.

UnitedHealthcare:

In-home midwives, birthing centers, and fetal monitors (including intrauterine devices) are covered. Certified midwives are covered on an in-network basis regardless of the provider’s network status.

Mental health and substance abuse residential treatment

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

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 2-20 for contact 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
- Educational services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to, boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based

- Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility, or residential treatment center. This exclusion includes procedures, equipment, services, supplies, or charges for the following:
 - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home, or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - Services or care provided or billed by a school, custodial care center for the developmentally disabled, or wilderness or outdoor camps and programs, and even if psychotherapy is included.

Also, refer to the “[Exclusions](#)” section starting on page 2-77.

Nutritional formulas

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

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 on page 2-35.

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 2-77.

Nutritionists

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

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 2-77.

Office visit — primary care physician (PCP) (in-person or virtual)

Note: Physicians who qualify as PCPs are listed below.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

The medical plans cover regular office visits with an eligible primary care physician (PCP), which includes:

- Family Medicine physicians
- General Practice physicians
- Internal Medicine physicians
- Nurse Practitioners
- Obstetricians and Gynecologists
- Pediatricians
- Physician Assistants

If you receive any services and supplies during 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, 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 on page 2-60 for more information about what you will pay.

When services are received from an out-of-network provider, you pay the amount above the allowed amount (eligible expense) in addition to the deductible and coinsurance applied. Amounts above the allowed amount do not apply toward the annual deductible or the annual out-of-pocket maximum.

Notes:

- An eye exam for individuals diagnosed with diabetes is covered at coinsurance, no deductible.
- For prescription drugs that require administration under the direct supervision of a health care professional and can be administered in the home, refer to the "[Prescription drug benefit](#)" section starting on page 2-85 for coverage information, pre-service authorization requirements and instructions, and how to order and ship specialty medications from the Accredo Specialty Pharmacy to the physician's office.

Not covered

- Services from a physician or provider who is not listed as an eligible primary care physician as defined on this page 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 on page 2-48.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the "[Prescription drug benefit](#)" section starting on page 2-85 for coverage information.

Also, refer to the "[Exclusions](#)" section starting on page 2-77.

Notes

For obstetrical and gynecological office visits related to pregnancy and maternity care, see the "[Maternity care](#)" section on page 2-51.

Office visit — non-primary care physician or specialist (in-person or virtual)

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

The medical plans cover regular office visits with a specialist or other physician or provider who is not defined as an eligible primary care physician (see the [“Office visit — primary care physician \(PCP\) \(in-person or virtual\)”](#) section on page 2-57 for a listing of the types of providers who are considered eligible primary care physicians). Some services may require pre-service authorization (see the [“Pre-service authorization requirements”](#) section starting on page 2-20). 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 2-60 for more information about what you will pay.

Notes:

- An eye exam for individuals diagnosed with diabetes is covered at coinsurance, no deductible.
- For prescription drugs that require administration under the direct supervision of a health care professional, refer to the [“Prescription drug benefit”](#) section starting on page 2-85 for coverage information, pre-service authorization requirements and instructions, and how to order and ship specialty medications from the Express Scripts 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 on page 2-48.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the [“Prescription drug benefit”](#) section starting on page 2-85 for coverage information.

Also, refer to the [“Exclusions”](#) section starting on page 2-77.

Office visit — outpatient mental health and substance abuse (in-person or virtual)

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

The medical plans cover outpatient office visits (including couples counseling) for professional mental health and substance abuse services for evaluation, crisis intervention, and treatment of mental and nervous disorders as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other professionally recognized reference publication acceptable to the claims administrator.

Note: Residential treatment, structured outpatient care, 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 on page 2-48.

Office visits for Applied Behavioral Analysis (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 on page 2-28.

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

If you receive any services and supplies during your office visit, those services and supplies, 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 may be billed separately from the office visit 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 on page 2-60 and the “[Psychological and neuropsychological testing](#)” section on page 2-66 for more information.

When services are received from an out-of-network provider, you pay the amount above the allowed amount (eligible expense) in addition to the deductible and coinsurance applied. Amounts above the allowed amount do not apply toward the annual deductible or annual out-of-pocket maximum.

Not covered

Refer to the “[Exclusions](#)” section starting on page 2-77.

Outpatient surgery, diagnostic, and therapeutic services

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

The medical plans cover outpatient surgery, diagnostic, and therapeutic services received on an outpatient basis in a physician's office, at a clinic, and at a hospital or alternate facility including:

- Diabetes outpatient self-management training and education, including medical nutrition therapy.
- Scheduled surgery, anesthesia, and related services.
- Scopic procedures — outpatient diagnostic and therapeutic.
 - Diagnostic scopic procedures are those for visualization, biopsy, and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.
 - Benefits do not include inpatient surgical scopic procedures. Benefits for inpatient surgical scopic procedures are covered in the [“Hospital inpatient services \(inpatient hospital, inpatient treatment, or other inpatient medical facility admissions\)”](#) section on page 2-48.
- 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.

Not covered

- Surgery that is intended to allow you to see better without glasses or other vision correction, including radial keratotomy, laser, and other refractive eye surgery.
- Prescription drugs that do not require administration under the direct supervision of a health care professional. The prescription drug benefit is administered by Express Scripts. Refer to the [“Prescription drug benefit”](#) section starting on page 2-85 for coverage information.

Also, refer to the [“Exclusions”](#) section starting on page 2-77.

Notes

UnitedHealthcare:

You or your provider must contact UnitedHealthcare for pre-service authorization before you receive the following services:

- CT or CAT scans (computer-aided tomography)
- Dialysis
- Imaging cardiac stress tests
- MRI scans (magnetic resonance imaging)
- Mammography testing
- PET scans, MRI, MRA, nuclear medicine, and major diagnostic services
- Prescription drugs that require administration under the direct supervision of a health care professional

If you use an in-network or an out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.

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

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

When more than one diagnostic procedure is performed within the same diagnostic family (for example, scopic procedures, x-rays, CT, or MRI) during the same session, one procedure will be considered at 100% of the eligible expense and the other procedures will be considered at 50% of the eligible expense.

Palliative care

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

The medical plans cover palliative care. Palliative care includes symptom management, education, and establishing goals for care if you have a medical condition with a prognosis of a life expectancy of two years or less.

Not covered

Refer to the “[Exclusions](#)” section starting on page 2-77.

Physician services — inpatient and outpatient facilities (other than an office visit charge)

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

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:
 - 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, the claims administrator will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.
 - Out-of-network surgeon fees in an emergency situation are considered at in-network benefit level.
 - 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 2-85 for coverage information, pre-service authorization requirements and instructions, and how to order and ship specialty medications from the Accredo specialty pharmacy to the outpatient facility administering the specialty medication.

Not covered

- Charges for a physician who does not perform a service but is on call.
- Routine physical examinations not required for health reasons, including but not limited to employment, insurance, government license, court-ordered, forensic, or custodial evaluations.
- Services of a Christian Science practitioner or nurse.
- Charges for Christian Science care in a Christian Science sanatorium.
- Internet or similar communications for the purpose of scheduling medical appointments, refilling or renewing existing prescription medications, reporting normal medical test results, providing education materials, updating patient information, requesting a referral, and services that would similarly not be charged for an on-site medical office visit.
- Cosmetic surgery or treatment related to the consequences of, or as a result of, non-covered cosmetic surgery as determined by the claims administrator.
- Repair of scars and blemishes on skin surfaces.
- Separate charges for pre- and postoperative care for surgery.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by Express Scripts. Refer to the [“Prescription drug benefit”](#) section starting on page 2-85 for coverage information.

Also, refer to the [“Exclusions”](#) section starting on page 2-77.

Notes

Services coded by your provider as received in an outpatient facility will be subject to the outpatient facility coinsurance.

Preventive care services (eligible preventive care services)

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	The medical plan pays 100% of eligible covered expenses.	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).	The medical plan pays 100% of eligible covered expenses.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	The medical plan pays 100% of eligible covered expenses.	You pay 30% of eligible covered expenses (you are not required to meet the annual deductible before eligible preventive care services are covered).

The medical plans cover

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

- 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 as you purchase or rent the pump through your claims administrator’s in-network hospital, physician, or durable medical equipment (DME) supplier. Under the HRA-Based Medical Plan Out-of-Area and the HSA-Based Medical Plan Out-of-Network, 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
- 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).

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
- Services that are recommended by one of several government or independent agencies responsible for the development and monitoring of U.S. preventive care guidelines, but 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 2-77.

Psychological and neuropsychological testing

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

The medical plans cover psychological and neuropsychological testing when conducted for the purpose of diagnosing a mental disorder in the most recent version of the DSM (*Diagnostic and Statistical Manual of Mental Disorders*), or other professionally recognized reference publication acceptable to the claims administrator, or in connection with treatment of such a mental disorder. **It is strongly recommended that you call the applicable claims administrator before receiving services** to ensure that the services you seek are covered under the plan.

In addition, you can get information about in-network providers available in your area. See the “[Pre-service authorization requirements](#)” section starting on page 2-20 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 2-77.

Reconstructive surgery

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 for more information). If pre-service authorization is received, the medical plans cover certain reconstructive procedures. Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part to address the following:

- Prompt repair of accidental injury that occurs while covered under the medical plan
- To improve function of a malformed body part
- To correct a defect caused by infection or disease

The medical plans also cover the cost of postmastectomy reconstructive surgery performed on you or your eligible covered dependents in a manner determined in consultation with the attending physician and patient for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The plan covers excess skin removal when the medical records document a skin condition causing a functional impairment and the proposed procedure meets the claims administrator's medical policy criteria for that procedure. Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section on page 2-20 for more information).

The plan covers penile prosthesis when deemed medically necessary as defined by the claims administrator.

Additional criteria:

- After significant weight loss unrelated to bariatric surgery, in addition to the criteria listed above, there must be documentation that a stable weight has been maintained for six months.
- After significant weight loss following bariatric surgery, in addition to meeting the criteria listed above, there must be documentation that a stable weight has been maintained for six months. This often occurs 12 to 18 months after surgery.

Not covered

- Cosmetic procedures, including but not limited to surgery, pharmacological regimens, nutritional procedures or treatments, scar or tattoo removal, revision procedures, or skin abrasion
- Dentures, regardless of the cause or condition, and any associated services or charges, including bone grafts
- Dental implants and any associated services and charges
- Liposuction
- Removal of excess skin or fat, or both when the procedure does not meet the claims administrator's medical criteria
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure
- Repair of scars and blemishes on skin surfaces
- Services related to teeth, the root structure of teeth, or supporting bone and tissue except as described in the [“Dental care”](#) section starting on page 2-33
- Treatment of benign gynecomastia (abnormal breast enlargement in males)

Also, refer to the [“Exclusions”](#) section starting on page 2-77.

Notes

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, the claims administrator will reduce the allowed amount based on the type of assistant surgeon assisting in the surgery.

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

Skilled nursing facility

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	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 days per plan year, in-network and out-of-network services combined.	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 days per plan year, in-network and out-of-network services combined.	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 days per plan year, in-network and out-of-network services combined.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 days per plan year, in-network and out-of-network services combined.	You pay 30% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 100 days per plan year, in-network and out-of-network services combined.

The medical plans cover

Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 for more information). If pre-service authorization is received, the medical plans cover an inpatient stay in a skilled nursing facility or acute inpatient rehabilitation facility. Benefits are limited to 100 days per plan year for skilled nursing, in-network and out-of-network services combined. There are no limits for acute inpatient rehabilitation services that meet the claims administrator's coverage policy criteria and are billed as acute inpatient rehabilitation services.

Benefits are available for:

- Services and supplies received during the inpatient stay
- Room and board in a semiprivate room (a room with two or more beds)

Skilled nursing provides benefits if you are recovering from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation, and facility services that are less than those of a general acute hospital but greater than those available in the home setting.

Benefits are available only when skilled nursing, rehabilitation services, or both, are needed on a daily basis. Benefits are not available when these services are required intermittently (such as physical therapy three times a week).

Not covered

- Custodial, domiciliary, or maintenance care (including administration of internal feeds), even when ordered by a physician. Custodial, domiciliary, or maintenance care includes but is not limited to help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs. It is primarily required to meet the patient's personal needs or maintain a level of function, as opposed to improving that function to allow for a more independent existence.
- Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- Services that do not require continued administration by trained medical personnel to be delivered safely and effectively.
- Treatment, services, or supplies that do not meet the definition of a covered health service.
- Private-duty nursing.

Also, refer to the [“Exclusions”](#) section starting on page 2-77.

Telemedicine/virtual visits (with certain in-network providers)

See below for details.

Plan	What you pay		
	In-network providers ^{1,2}	Out-of-network providers	Out of Area* coverage ²
HRA-Based Medical Plan	The medical plan pays 100% of eligible covered expenses for only the telemedicine/virtual visit charge when one of UnitedHealthcare's telemedicine/virtual visit applications is used.	If you consult with a provider online or by phone who is not associated with UnitedHealthcare's telemedicine/virtual visit applications, refer to the “Office visit — primary care physician (PCP) (in-person or virtual)” section on page 2-57, the “Office visit — non-primary care physician or specialist (in-person or virtual)” section on page 2-58, or the “Office visit — outpatient mental health and substance abuse (in-person or virtual)” section on page 2-59 for coverage and cost-sharing information.	The medical plan pays 100% of eligible covered expenses for only the telemedicine/virtual visit charge when one of UnitedHealthcare's telemedicine/virtual visit applications is used.

1. **UnitedHealthcare's** telemedicine/virtual visit applications are: Teladoc, Amwell, and Doctor on Demand (accessed through myuhc.com). **UnitedHealthcare's** behavioral health telemedicine/virtual visit applications are Amwell, and Doctor on Demand (accessed through myuhc.com). All are subject to change at any time by claims administrator.
2. 100% coverage does not apply to other services and supplies you may receive in connection with the telemedicine/virtual visit, including but not limited to diagnostic services (for example, lab work) or for any services performed by another physician or specialist who may be brought into the telemedicine/virtual visit to provide further consultation or diagnosis, or recommend treatment, even if those services are performed during the telemedicine/virtual visit. If you receive other services or supplies during the telemedicine/virtual visit, those charges may be billed separately, and eligible expenses are subject to the deductible and applicable coinsurance.

Plan	What you pay	
	In-network providers ^{1,2}	Out-of-network providers
HSA-Based Medical Plan	The medical plan pays 100% of eligible covered expenses for only the telemedicine/virtual visit charge when one of UnitedHealthcare's telemedicine/virtual visit applications is used.	If you consult with a provider online or by phone who is not associated with UnitedHealthcare's telemedicine/virtual visit applications, refer to the “Office visit — primary care physician (PCP) (in-person or virtual)” section on page 2-57, the “Office visit — non-primary care physician or specialist (in-person or virtual)” section on page 2-58, or the “Office visit — outpatient mental health and substance abuse (in-person or virtual)” section on page 2-59 for coverage and cost-sharing information.

1. **UnitedHealthcare's** telemedicine/virtual visit applications are: Teladoc, Amwell, and Doctor on Demand (accessed through [myuhc.com](#)). **UnitedHealthcare's** behavioral health telemedicine/virtual visit applications are Amwell, and Doctor on Demand (accessed through [myuhc.com](#)). All are subject to change at any time by claims administrator.
2. 100% coverage does not apply to other services and supplies you may receive in connection with the telemedicine/virtual visit, including but not limited to diagnostic services (for example, lab work) or for any services performed by another physician or specialist who may be brought into the telemedicine/virtual visit to provide further consultation or diagnosis, or recommend treatment, even if those services are performed during the telemedicine/virtual visit. If you receive other services or supplies during the telemedicine/virtual visit, those charges may be billed separately, and eligible expenses are subject to the deductible and applicable coinsurance.

The medical plans cover

Refer to the tables above.

Not Covered

- Out-of-network telemedicine/virtual visits
- Refer to the [“Exclusions”](#) section starting on page 2-77

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

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	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 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.	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 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.	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 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.

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

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.	You pay 30% of eligible covered expenses after you satisfy the deductible. Benefits are limited to 90 visits per plan year for speech therapy, occupational therapy, and physical therapy combined, in-network and out-of-network services combined.

The medical plans cover

Services may be subject to pre-service authorization requirements (see the “[Pre-service authorization requirements](#)” section starting on page 2-20 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.

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. Benefits are 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 and/or pleoptic training, amblyopia, exotropia with continued medical direction and evaluation.

Not covered

- 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.
- Eye exercise for vision therapy for those age 18 or older.
- Hippotherapy.
- Prolotherapy.
- Therapy for voice modulation or similar training (including to teach people to speak another language). Articulation when it's the sole focus of therapy and not related to a neurological motor planning disorder.
- Therapy services that do not meet the claims administrator's criteria guidelines.
- Therapy that has not been approved by the claims administrator.
- Therapy to improve general physical condition or performance.

Also, refer to the "[Exclusions](#)" section starting on page 2-77.

Transplant services

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.	Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses after you satisfy the in-network deductible.	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.

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

The medical plans cover

Pre-service authorization is required (see the [“Pre-service authorization requirements”](#) section starting on page 2-20 for more information). If pre-service authorization is received, the medical plans cover organ, bone marrow, and tissue transplants as explained below.

Covered health services and supplies for the following organ or tissue transplants are payable when ordered by a physician. The claims administrator must be notified at least seven working days before the scheduled date of any of the following, or as soon as reasonably possible:

- Evaluation
- Donor search
- Organ procurement or tissue harvest
- Organ transplants

In case of an organ or tissue transplant, donor charges are considered covered health services only if the recipient is a covered person. If the recipient is not a covered person, no benefits are payable for donor charges.

The search for bone marrow or stem cells from a donor who is not biologically related to the patient is not considered a covered health service unless the search is made in connection with a transplant procedure arranged by a designated facility.

If a qualified procedure is a covered health service and performed at a designated facility, the medical care, treatment, transportation, and lodging provisions apply.

Qualified procedures include but are not limited to the procedures listed below. The claims administrator's medical policies determine if a procedure is a qualified procedure.

- Heart
- Heart and lung
- Liver
- Lung (single or double)
- Pancreas for a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session, or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired
- Kidney
- Liver and kidney
- Intestine
- Liver and intestine
- Cornea — you are not required to notify the plan administrator of a cornea transplant, nor is the cornea transplant required to be performed at a designated facility
- Bone marrow and stem cells
- Pancreas
- Kidney and pancreas
- Other transplant procedures when the claims administrator determines that it is medically appropriate to perform the procedure at a designated facility

Medical care and treatment — the covered expenses for services provided in connection with the transplant procedure include:

- Pretransplant evaluation for one of the procedures listed above
- Organ acquisition and procurement
- Hospital and physician fees
- Transplant procedures
- Follow-up care for a period up to one year after the transplant
- Search for bone marrow and stem cells from a donor who is not biologically related to the patient

A designated facility has entered into an agreement with the claims administrator or with an organization contracting on behalf of the medical plans to provide covered health services for the treatment of specified diseases or conditions.

A designated facility may or may not be located within your geographic area. To be considered a designated facility, the facility must meet certain standards of excellence and have a proven track record of treating specified conditions as determined by the claims administrator. The fact that a hospital is considered in-network under the medical plan does not mean that it is a designated facility.

Not covered

- Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood-producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary
- Living donor organ or tissue transplants unless otherwise specified in this SPD
- Transportation and lodging expenses not coordinated by the applicable claims administrator
- Expenses in excess of the stated reimbursement or benefit limits
- Nonhuman organ implants or transplants
- Other transplants not specifically listed in this SPD
- Services that would not be performed but for the transplant, even as a result of complications
- Treatment of medical complications that may occur to the donor; donors are not considered covered persons, and are therefore not eligible for the rights afforded to covered persons under this SPD
- Benefits for travel and lodging expenses when you are not using a designated facility

Refer to the “[Prescription drug benefit](#)” section starting on page 2-85 for prescription drug coverage information and prescriptions that are not covered. Also, refer to the “[Exclusions](#)” section starting on page 2-77.

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 2-75 for information about covered travel expenses related to transplant surgery. Refer to the “[Prescription drug benefit](#)” section starting on page 2-85 for prescription drug coverage information and pre-service authorization requirements and instructions.

Transportation and lodging for bariatric services, infertility and fertility services and treatment, transplants, gender reassignment surgery, cancer, congenital heart disease (CHD), and spine (back) and joint (knee and hip) surgery

The claims administrator will assist the patient and family with travel and lodging arrangements if the patient meets the criteria to receive services and resides more than 50 miles from a:

- Designated facility
- Qualified provider (as determined by the claims administrator) for gender reassignment services (available only under UnitedHealthcare)

Expenses for travel and lodging for the covered person and a companion are available as follows:

- Transportation of the patient and one companion who is traveling on the same days to or from the designated facility (as listed above) for the purposes of an evaluation, an approved surgical procedure, or necessary postdischarge follow-up.
- Reasonable and necessary expenses, as determined by the claims administrator, for lodging for the patient and one companion.

- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed as determined by the claims administrator.
- Eligible spine (back) and joint (knee and hip) surgeries have a \$2,000 annual combined maximum transportation and lodging reimbursement limit.

Urgent Care Clinics

Plan	What you pay		
	In-network providers	Out-of-network providers	Out of Area* coverage
HRA-Based Medical Plan	Available HRA dollars pay 100% of eligible covered expenses, then you pay 20% of eligible covered expenses after you satisfy the deductible.	Available HRA dollars pay 100% of eligible covered expenses, then you pay 40% of eligible covered expenses after you satisfy the in-network deductible.	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.

Plan	What you pay	
	In-network providers	Out-of-network providers
HSA-Based Medical Plan	You pay 10% of eligible covered expenses after you satisfy the deductible.	You pay 30% of eligible covered expenses after you satisfy the deductible.

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 acupuncture, aromatherapy, hypnotism, rolfing, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health except as noted in the [“Homeopathic and naturopathic services”](#) section on page 2-46.

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 procedures

These include medical, surgical, diagnostic, mental health, substance abuse, wilderness or outdoor therapy (including but not limited to outdoor camps, programs, or the like), or other health care services, technologies, supplies, treatments, therapies, procedures, programs, drug therapies, or devices that, at the time the utilization review organization or the claims administrator makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight, except as otherwise noted in this chapter

Unproven services

These include medical, surgical, diagnostic, mental health, substance abuse, wilderness or outdoor therapy (including but not limited to outdoor camps, programs, or the like), or other health care services, technologies, supplies, treatments, therapies, procedures, programs, drug therapies, or devices where, at the time the utilization review organization or the claims administrator makes a determination regarding coverage in a particular case:

- Reliable, authoritative evidence (as determined by the applicable claims administrator) does not permit conclusions

concerning the service’s safety, effectiveness, or effect on health outcomes as compared with the standard means of treatment or diagnosis

- The conclusions determine that the treatment, service, or supply is not effective
- Conclusions are not based on trials that meet either of the following designs:
 - Well-conducted, randomized controlled trials in which two or more treatments are compared with each other, and the patient is not allowed to choose which treatment is received
 - Well-conducted cohort studies in which patients who receive study treatment are compared with a group of patients who received standard therapy; the comparison group must be nearly identical to the study treatment group

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research based on well-conducted randomized trials or cohort studies as determined by the applicable claims administrator.

Physical appearance

- Cosmetic procedures
 - Cosmetic procedures are services that change or improve appearance without significantly improving the primary physiological function of the body part on which the procedure was performed, as determined by the claims administrators
 - Cosmetic treatments relating to the consequences of, or as a result of non-covered cosmetic surgery as determined by the claims administrator
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, and flexibility
- Counseling for diversion or general motivation
- Treatment, services, or supplies for unwanted hair growth
- Removal of excess skin or fat, or both, when the procedure does not meet the claims administrator’s medical criteria
- Wigs for androgenetic alopecia, which is the most common form of hair loss encompassing conditions such as male pattern baldness or hair thinning

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child, including any service the provider may perform on 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 2-75
- 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 2-85 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 an in-network provider is required to write off
- Charges for a standby provider or facility when no actual services have been performed
- Charges for giving injections that can be self-administered
- Charges for or associated with patient advocacy
- 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 for services needed because the patient was engaged in an illegal activity when the injury occurred
- Charges for the purchase or replacement of contact lenses or glasses
- Charges in excess of eligible expenses or in excess of any specified limitation
- Charges made for routine refractions, eye exercises, vision therapy for those age 18 and older, and surgical treatment for correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn
- Charges or costs associated with sperm or ovum donations or the storage thereof

- 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 or coinsurance requirement of such a policy
- 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
- Child care costs, including day care centers and individual child care
- Claims filed more than 12 months after the date of treatment or services
- Clinical trials, except routine care associated with clinical trials for cancer or another life-threatening disease or condition
- Comfort or convenience items
- Cranial bands, banding, remolding, and helmets (except as noted in this chapter)
- 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 2-56
- Enuresis alarms, even if prescribed by a physician
- Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs
- Foot care — hygienic and preventive maintenance foot care
- Foot care — treatment of flat feet
- Foot care — treatment of subluxation of the foot
- Gene therapy, as well as any services, including drugs, procedures, and health care services related to it that introduce or are related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material
- Growth hormone therapy (see the "[Prescription drug benefit](#)" section starting on page 2-85 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 on page 2-23 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 educational materials, updating patient information, and requesting a referral, and services that would similarly not be charged for an on-site medical office visit
- Massage therapy unless noted specifically in this SPD
- Medical and surgical treatment and oral appliances for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- 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 as noted specifically in this SPD
- Personal comfort items, such as telephone, television, barber and beauty supplies, and guest services
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the medical plan when:
 - Conducted for purposes of medical research
 - Related to judicial or administrative proceedings or orders
 - Required solely for purposes of career, education, sports or camp, employment, insurance, marriage, or adoption
 - Required to obtain or maintain a license of any type
- Private-duty nursing (see the "[Extended skilled nursing care](#)" section on page 2-39 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 and treatment of infertility after reversal of voluntary sterilization and any related charges
- Routine vision screening after age 21
- Services a provider gives to himself or herself or to a close relative (such as a spouse, brother, sister, parent, grandparent, or child)
- 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 specified in the “[Transplant services](#)” section on page 2-73
- Services for hospital confinement primarily for diagnostic studies
- 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 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 specified in the “[Dental care](#)” section on page 2-33
- Services for or related to fetal tissue transplantation
- Services for or related to functional capacity evaluations for vocational purposes or determination of disability or pension benefits
- Services for or related to recreational therapy (defined as the prescribed use of recreation and other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, or social disadvantages) or educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including but not limited to health club memberships, aerobic conditioning, therapeutic exercises, massage therapy, and work-hardening programs, and all related material and products for these programs
- Services for or related to smoking cessation program fees or related program supplies
- 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
- Services performed before the effective date of coverage under the applicable medical plan
- Services prohibited by law or regulation
- 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 2-48)
- Services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants except services related to the implant or removal of a 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
- Surgical treatment of obesity, excluding morbid obesity
- Transitional living services
- Treatment by artificial means for the purpose of causing a pregnancy, including but not limited to prescription drugs and ART procedures, including but not limited to IVF, gamete intracytopreservation, or frozen embryo transfer
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Treatment of excessive sweating (hyperhidrosis)
- Treatment where payment is made by any local, state, or federal government (except Medicaid) or for which payment would be made if the member had applied for such benefits
- Tuition for or services that are school-based for children and adolescents
- Ultrasonic nebulizers, even if prescribed by a physician
- 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)
- Varicose vein treatment of the lower extremities, when it is considered cosmetic; this includes treatment of spider veins and reticular veins
- Vision correction surgery

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 2-20.

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 Retiree Plan will defer to such determination of the attending provider who filed the urgent care claim. Where the attending provider has not determined that the claim is an urgent care claim, the claims administrator will determine if the claim is an urgent care claim.

Claims administrator	Contact
UnitedHealthcare	Phone: 1-800-842-9722
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 2-20.

Claims administrator	Contact	Address
UnitedHealthcare	Phone: 1-800-842-9722	UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130

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 (see the “[Contacts](#)” section on page 2-3). You may also call the claims administrator’s member service 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.

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.

Mailing address for post-service claims

Claims administrator	Address
UnitedHealthcare	UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130

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

After your claim has been processed according to the terms of the plan in which you are enrolled, if you received covered health services from an in-network provider, the in-network level benefit payment (or if applicable, the Out of Area coverage benefit payment) is made to the in-network provider. You are responsible for the applicable in-network (or if applicable, the Out of Area coverage) annual deductible and coinsurance. 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.

After your claim has been processed according to the terms of the plan in which you are enrolled, if you received covered health services from an 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 or coinsurance. In addition, you must pay the full cost for all charges not covered by the plan.

Note: An assignment to pay the out-of-network provider generally does not assign any other rights under the Retiree Plan to that provider, including the right to request plan documents or pursue and appeal an adverse benefit determination on your behalf.

Claim denials and appeals

If you have a question or concern about a claim, you may call the claims administrator at UnitedHealthcare at 1-800-842-9722.

In the event your claim is denied (in whole or in part), you may also file a formal appeal under the terms of the Retiree Plan. Note that if you call the claims administrator, your call will not be considered a formal appeal under the terms of the Retiree 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 that 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 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 Retiree 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 Retiree Plan.

Complete information on appeals is provided in "[Appendix A: Claims and Appeals](#)."

Right of recovery

The HRA-Based Medical Plan and the HSA-Based Medical Plan, as well as the Express Scripts administered prescription drug benefit, are part of the Wells Fargo & Company Retiree Plan (the Retiree Plan). The Retiree 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 Retiree 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 Retiree 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 Retiree Plan's benefit to the extent of subrogation or reimbursement claims.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made from such constructive trust until the Retiree Plan's subrogation and reimbursement interests are fully satisfied. You agree to cooperate fully in every effort by the Retiree Plan to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to inform the Retiree Plan in writing within 30 days of giving notice to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents also agree to provide written notice to the Retiree Plan prior to receipt of any recovery or within 5 days if no notice was given prior to your receipt of the funds.

Recovery of overpayments

If the Retiree Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree Plan. The claims administrator or the plan administrator, on behalf of the Retiree Plan, may send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Retiree 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 Retiree Plan
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Retiree Plan

Reimbursement policy

The right of reimbursement means you must repay the Retiree 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 Retiree 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 Retiree 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 Retiree Plan a first priority lien against any proceeds of any settlement, verdict, or insurance proceeds received by you or on your behalf as a result of the third party's actions and are to be repaid to the Retiree Plan before you receive any recovery for your damages
- Assign to the Retiree Plan any benefits you may receive under any automobile policy or other insurance coverage, to the full extent of the Retiree Plan's claim for reimbursement

You must sign and deliver to the claims administrator or the plan administrator on behalf of the Retiree Plan, as directed, any documents needed to protect the Retiree 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 Retiree 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 Retiree 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 Retiree Plan after receipt of a settlement, verdict, judgment, award, or insurance proceeds, the Retiree Plan may not pay for any future medical expenses, whether anticipated or unanticipated, relating to your injury or medical condition. In addition, the Retiree Plan may seek legal action against you to recover paid medical benefits related to your injury or medical condition. In addition, the Retiree 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 Retiree Plan.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator, in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Subrogation

Under the reimbursement method of subrogation, you reimburse the Retiree Plan any money you receive through a settlement, verdict, judgment, award, or insurance proceeds. At its sole discretion, the Retiree Plan also has the option of directly asserting its rights against the third party through subrogation. This means that the Retiree Plan is subrogated to all of your rights against any third party who is liable for your injury or medical condition. The Retiree 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 Retiree Plan. The Retiree Plan may make a claim in your name or the Retiree Plan's name against any persons, organizations, or insurers on account of such injury or medical condition. The Retiree Plan may assert this right independently of you.

You are obligated to cooperate with the Retiree Plan and its agents to protect the Retiree Plan's subrogation rights. Cooperation means providing the Retiree Plan or its agents with any relevant information as requested, signing and delivering such documents as the Retiree Plan or its agents request to secure the Retiree Plan's subrogation claim, and obtaining the Retiree 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 Retiree Plan. Any costs incurred by the Retiree Plan in matters related to subrogation may be paid for by the Retiree Plan. The costs of legal representation you incur will be your responsibility.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Interpretation

In the event that any claim is made that any part of this "Right of Recovery" section is ambiguous, or questions arise concerning the meaning of the intent of any of its terms, the plan administrator or its designee shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this "Right of Recovery" section. The Retiree Plan's rights reflected in this "Right of Recovery" section are in addition to and not in lieu of any similar rights the Retiree Plan may have in connection with the dental or vision benefit options under the Retiree 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 Retiree 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 Retiree Plan or its designee may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond to you by reason of your present or future domicile.

The basics

Express Scripts administers the prescription drug benefits offered under the HRA-Based Medical Plan* and the HSA-Based Medical Plan.

* Including Out of Area. Unless otherwise indicated, references in this “Prescription drug benefit” section to the HRA-Based Medical Plan and the HSA-Based Medical Plan also apply to the applicable Out of Area coverage.

Prescriptions must be written by a medical provider licensed to prescribe medications. Coverage is determined based on Express Scripts’ coverage criteria. In addition, all prescriptions are subject to the limits, exclusions, and procedures described in this “Prescription drug benefit” section of this chapter. Not all medications are covered by the prescription drug benefit (even if other medications in the same therapeutic class are covered). To obtain information on the established criteria, or to find out if your drug is on the Express Scripts National Preferred Drug List (a listing of preferred drugs) or is subject to certain prescription drug benefit provisions, visit express-scripts.com or call Express Scripts Member Services at 1-855-388-0352.

Filling your prescription

Where you fill your medication will depend on the type of medication you take.

Short-term medications

Short-term medications are generally those you take for less than 90 days. They may be antibiotics or a short-term prescription for a pain medication.

You can fill up to a 30-day supply of your prescription at any retail pharmacy, but you can take advantage of discounted network rates if you use a pharmacy that participates in the Express Scripts retail pharmacy network. When you have a prescription filled at an in-network retail pharmacy, you’ll typically pay less than if you have a prescription filled at a nonparticipating pharmacy.

Maintenance medications

Maintenance medications are those you take on a regular, ongoing basis for chronic, long-term conditions such as those used to control blood pressure. This does not include drugs your doctor prescribes for a short-term condition, such as antibiotics.

Generally, you will pay less for your maintenance medications if you fill a 90-day supply through Express Scripts Home Delivery or at a CVS Pharmacy store. As long as your doctor writes a prescription for a 90-day supply for the maintenance medications, the total cost of the medication will generally be less than the cost of purchasing multiple 30-day supplies for the same medication.

Specialty medications

Specialty medications are used to manage long-term (chronic), rare, and complex conditions or genetic disorders. These include, but are not limited to, rheumatoid arthritis, cancer, multiple sclerosis, growth hormone disorders, and immune deficiencies. The medications are often injectable or intravenously (IV) infused, but may also be taken orally or inhaled. They may have special storage and handling needs and cost more than other drugs because of the way the drugs are made. Specialty medications must be filled through Accredo, your specialty pharmacy. See the [“Accredo, your specialty pharmacy”](#) section starting on page 2-90 for more information.

Filling your prescription at a retail pharmacy

Bring your Express Scripts ID card and pay your portion, as shown in the [“What you’ll pay for prescriptions: HRA-Based Medical Plan”](#) table on page 2-88, or in the [“What you’ll pay for prescriptions: HSA-Based Medical Plan”](#) table on page 2-89, for up to a 30-day supply of each prescription, depending on the medical plan in which you are enrolled. Some drugs require pre-service authorization, so be sure to review the [“Some prescriptions may require pre-service authorization, step therapy, or quantity limits”](#) section starting on page 2-91 before filling a prescription for the first time.

If you use an out-of-network retail pharmacy, you’ll be asked to pay 100% of the prescription price at the pharmacy and then file a paper claim form with the original prescription receipt to Express Scripts. If it’s a covered prescription, Express Scripts will reimburse you as shown in the [“What you’ll pay for prescriptions: HRA-Based Medical Plan”](#) table on page 2-88, or in the [“What you’ll pay for prescriptions: HSA-Based Medical Plan”](#) table on page 2-89, for up to a 30-day supply per prescription, depending on the medical plan in which you are enrolled.

To locate an Express Scripts participating pharmacy:

- Visit Express Scripts’ website at express-scripts.com
- Call Express Scripts Member Services at 1-855-388-0352

Filling your prescription through Express Scripts Home Delivery

Express Scripts Home Delivery is available for most prescriptions that you take on a regular basis. Consult with your doctor regarding your prescription if you intend to use Express Scripts Home Delivery. You will generally pay less if you order a 90-day supply of your medication through Express Scripts Home Delivery.

With Express Scripts Home Delivery you get:

- Up to a 90-day supply of covered drugs for one copay, or coinsurance payment, as applicable (see the [“What you’ll pay for prescriptions: HRA-Based Medical Plan”](#) table on page 2-88, or in the [“What you’ll pay for prescriptions: HSA-Based Medical Plan”](#) table on page 2-89)
- Access to registered pharmacists 24 hours a day, 7 days a week
- Ability to refill orders online, by phone, or by mail — any time of the day or night
- Free standard shipping (overnight or second-day delivery may be available in your area for an additional charge)

Although most prescriptions taken on a regular basis can be ordered through Express Scripts Home Delivery, certain medications are not available through home delivery, are not able to be written for up to a 90-day supply, or are subject to additional pharmacy regulations. Prescriptions that may have such limitations may include but are not limited to controlled substances such as certain pain medications or attention deficit disorder drugs. Certain drugs have limits on the quantity that can be dispensed, as determined by Express Scripts. If your quantity is limited based on clinical guidelines or by an Express Scripts program, your copay amount may be prorated, as determined by Express Scripts.

Ordering prescriptions

Once you have filled a prescription through Express Scripts Home Delivery, you can order refills by mail in three ways. It is recommended that you order your refill 14 days before your current prescription runs out. Suggested refill dates will be included on the prescription label you receive from Express Scripts.

Three ways to order prescriptions:

- **Online.** Go to express-scripts.com. If you are a first-time visitor, you’ll need to register using your Express Scripts ID number (shown on your Express Scripts ID card).
- **By phone.** (existing prescriptions only)

Call Express Scripts Member Services at 1-855-388-0352 for fully automated refill service. Have your Express Scripts ID number ready.

- **By mail.**

- For existing prescriptions:

- Complete a home delivery order form (available on express-scripts.com), attach the refill label provided with your last order, and enclose your payment with your order.

- For new prescriptions:

- Complete a home delivery order form (available on express-scripts.com), send it to Express Scripts along with your prescription, and enclose your payment with your order.

You can expect your medicine to arrive approximately 10 calendar days after Express Scripts receives your prescription. If you are currently taking a medication, it is recommended that you have at least a 14-day supply on hand when you order to ensure that you do not run out of your current supply before you receive your refill.

Overnight or second-day delivery may be available in your area for an additional charge. Your package will include a new home delivery order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medicine that you would receive from a retail pharmacy.

Not all prescription drugs are available via mail due to state and federal regulations.

Note: Prescription drugs received via home delivery cannot be returned. You will be responsible for the applicable cost share for prescription drugs you or your physician orders via mail.

Covered prescriptions

For your prescription to be covered, it must meet Express Scripts’ coverage criteria. In addition, all prescriptions are subject to the limitations, exclusions, and procedures described in this chapter. When more than one definition or provision applies, the most restrictive applies and exclusions take precedence over general benefits descriptions.

The following prescription types are generally covered, but some may require pre-service authorization (also known as pre-authorization, pre-approval, prior approval, prior authorization, pre-notification, pre-certification, or pre-auth), may be limited in the amount you can get at any one time, may be limited by the age of the patient, or may be limited to a specific pharmacy.

- Drugs that legally require a prescription, including compounded drugs where at least one ingredient requires a prescription, subject to the exceptions listed in this section
- Diabetic test strips, alcohol swabs, and lancets
- Insulin, insulin pen, insulin prefilled syringes, needles, and syringes for self-administered injections
- Certain preventive over-the-counter drugs or items as required by federal law

The list of preferred drugs, covered drugs, noncovered drugs, and coverage management programs and processes is subject to change at any time without prior notice. As new drugs become available, they will be considered for coverage under the prescription drug benefit. Newly introduced drugs may not be covered during this review period, and not all drugs will be covered.

Patient Assurance ProgramSM

Effective 1/1/2020, Wells Fargo is participating in the Patient Assurance ProgramSM administered by Express Scripts. If you fill a prescription for a participating insulin product on the national preferred drug list, your maximum out-of-pocket cost will be \$25.00 for a 30-day supply and \$75.00 for a 90-day supply (90-day supplies are only available at a CVS pharmacy or through Express Scripts Home Delivery [mail order]). You must use a network pharmacy or Express Scripts Home Delivery (mail order) to receive the discount. To confirm if your insulin is on the Patient Assurance ProgramSM list, visit express-scripts.com/wf. The list is located under “Explore your plan options”, within “Your Plan” and “Your Type.”

Note: The insulin on the Patient Assurance ProgramSM list is subject to change and this program may be discontinued at any time.

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.

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 Express Scripts Home Delivery, 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 amount 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, step therapy, or quantity limits](#)” section starting on page 2-91 for more information.)

Note: If your drug or supply is not on the preventive therapy drug list, you must meet the annual deductible before benefits are available.

National Preferred Drug List

Certain prescription drugs are included on the Express Scripts National Preferred Drug List (a listing of preferred drugs). This list, sometimes called a formulary, includes a wide selection of generic and brand-name drugs. Express Scripts maintains the Express Scripts National Preferred Drug List, including ensuring that the list is reviewed and updated regularly by an independent pharmacy and therapeutics committee. The list is continually revised by Express Scripts to ensure that the most up-to-date information is taken into account. Go to express-scripts.com or call 1-855-388-0352 to see if your prescription is on the list.

Drug categories

The prescription drug benefit categorizes prescriptions as follows:

- **Generic prescription drugs.** Generic drugs generally cost less than therapeutically equivalent brand-name drugs. Most drugs that are no longer under patent protection may be available in a generic form from multiple manufacturers. Express Scripts determines which drugs are considered generic based on data from an industry standard independent third party. It is unusual, but possible, for a drug to be classified as a generic and then to be reclassified as a brand at a later time. If you are prescribed such a drug, contact your provider for treatment options.

The Food and Drug Administration (FDA) ensures that generic drugs meet the same standards for safety and effectiveness as their brand-name equivalents.

- **Preferred brand-name drugs.** Brand-name prescription drugs that are on the National Preferred Drug List as determined by Express Scripts.

These drugs may or may not have generic equivalents available.

- **Nonpreferred brand-name drugs.** Brand-name prescription drugs that are not on the National Preferred Drug List as determined by Express Scripts.

You'll generally pay more for nonpreferred brand-name drugs that are covered under the plan.

- **Specialty drugs.** These are typically drugs that are self-injectable or require special handling, oral chemotherapy drugs, or drugs that treat complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis. For more information, see the “[Accredo, your specialty pharmacy](#)” section on page 2-90.

What you'll pay for prescriptions: HRA-Based Medical Plan

You do not pay a deductible for prescription drug costs and prescription drug copays do not count toward your medical annual deductible; however, copays do count toward your annual out-of-pocket maximum. In addition, HRA dollars, if available, cannot be used to cover your prescription drug copays or other costs. See the “[Important terms](#)” section starting on page 2-7 for more information about the annual deductible and annual out-of-pocket maximum.

Type of drug	In-network retail pharmacy (up to a 30-day supply)	Out-of-network retail pharmacy (up to a 30-day supply)	Express Scripts Home Delivery (up to a 90-day supply) or CVS Pharmacy store (84- to 90-day supply)
Generic drugs	You pay a \$10 copay. ^{1, 2}	You pay a \$10 copay. ^{1, 2} You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a \$20 copay. ^{1, 2}
Preferred brand-name drugs	You pay a \$100 copay. ^{1, 2, 3}	You pay a \$100 copay. ^{1, 2, 3} You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a \$200 copay. ^{1, 2, 3}
Nonpreferred brand-name drugs	You pay a \$150 copay. ^{1, 2, 3}	You pay a \$150 copay. ^{1, 2, 3} You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a \$300 copay. ^{1, 2, 3}
Specialty medications	Not Covered	Not Covered	Only covered through Accredo specialty pharmacy delivery. You pay a \$400 copay for a 90-day supply (copay is prorated for 30- or 60-day supply). ^{1, 2, 3}

1. The deductible does not apply. You cannot use HRA dollars to pay for your copay or other prescription drug costs.

2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum.

3. When you purchase a brand-name drug and a generic is available, you will pay the generic drug copay plus the difference in cost between the generic and brand-name drug.

What you'll pay for prescriptions: HSA-Based Medical Plan

You must satisfy your annual deductible under the HSA-Based Medical Plan before you begin paying the coinsurance amounts listed in the table below, unless your drug is on the preventive therapy drug list. Go to express-scripts.com or call Express Scripts at 1-855-388-0352 to see if your prescription is considered to be a preventive therapy drug. Your prescription costs, including the annual deductible, apply to your annual out-of-pocket maximum. See the “[Important terms](#)” section starting on page 2-7 for more information about the annual deductible and annual out-of-pocket maximum.

Type of drug	Network retail pharmacy (up to a 30-day supply)	Out-of-network retail pharmacy (up to a 30-day supply)	Express Scripts Home Delivery (up to a 90-day supply) or CVS Pharmacy store (84- to 90-day supply)
Medications on the preventive therapy drug list — generic, preferred brand, and nonpreferred brand	You pay 10% of covered charges; no deductible applies.	You pay 10% of the contracted rate plus the difference between the full cost and the Express Scripts discounted amount.	You pay 10% of covered charges; no deductible applies.
Nonpreventive medications — generic, preferred brand, and nonpreferred brand	You pay 10% of covered charges after you satisfy the deductible.	You pay 10% of the contracted rate plus the difference between the full cost and the Express Scripts discounted amount.	You pay 10% of covered charges after you satisfy the deductible.
Specialty medications	Not covered	Not covered	Only covered through Accredo specialty pharmacy delivery. You pay 10% of covered charges after you satisfy the deductible.

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 express-scripts.com or call Express Scripts Member Services at 1-855-388-0352 to see if your prescription is considered to be a preventive therapy drug. The preventive therapy drug list is subject to change.

Additional prescription drug coverage provisions

The following provisions also apply to all prescription drug claims processing under the HRA-Based Medical Plan and the HSA-Based Medical Plan:

- 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.
 - 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.
- 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 Express Scripts' pricing tools and cost estimates. Any difference in cost between the brand-name and generic is not applied to any applicable copays, coinsurance, deductible, or to the out-of-pocket maximum listed above. If there is a clinical reason that you cannot take a generic drug, your doctor can submit a request to Express Scripts for review. If the request is approved, you will pay the applicable nonpreferred brand-name drug cost amount listed above. Your doctor can fax the request to the Express Scripts Appeals Department at 1-877-328-9660.
- There are no exceptions to any other copay or coinsurance amounts listed, even with a physician's request. For example, if the drugs on the National Preferred Drug List are not appropriate for you, and you choose a drug that's not on the list, you will still have to pay the copay or coinsurance amount.
- Prescriptions for 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 "Accredo, your specialty pharmacy" section starting on this page.
- Express Scripts Home Delivery is the only covered mail order provider. Any drugs ordered by mail from another provider or service will not be covered.
- Certain prescriptions have quantity limits based on FDA, manufacturer, or clinical guidelines, as determined by Express Scripts.

- You'll need to request pre-service authorization from Express Scripts for certain prescriptions. For more information, see the ["Some prescriptions may require pre-service authorization, step therapy, or quantity limits"](#) section on page 2-91.

Your ID card

Shortly after you enroll in the HRA-Based Medical Plan or the HSA-Based Medical Plan, you'll receive an ID card from Express Scripts. You'll need to present your ID card each time you purchase prescription drugs at a participating pharmacy. If you do not have your ID card with you, you can pay for your prescription up front and file a claim for reimbursement with Express Scripts.

You can also go to [express-scripts.com](https://www.express-scripts.com) to print an ID card.

Accredo, your specialty pharmacy

Complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis are treated with specialty drugs. These are typically drugs that are self-injectable or require special handling, or oral chemotherapy drugs. Accredo is a comprehensive specialty pharmacy that provides these products directly to covered individuals along with supplies, equipment, and care coordination.

Contact Accredo toll-free at 1-800-803-2523 to get:

- Personal attention from experts specializing in your specific conditions
- Expedited, confidential delivery
- A specialty-trained pharmacist or nurse to provide customized care, counseling on how to best manage your condition, patient education, and evaluations to assess your progress on therapy and to discuss your concerns
- Specialty-trained pharmacists who are available 24 hours a day for emergency consultations
- Coordination of home care and other health care services

Certain specialty medications may not be available through the Accredo specialty pharmacy due to limited distribution from the manufacturer. If you fill a limited distribution specialty drug, you will pay the retail pharmacy copay or cost-share amount. See the applicable ["What you'll pay for prescriptions: HRA-Based Medical Plan"](#) table on page 2-88, or in the ["What you'll pay for prescriptions: HSA-Based Medical Plan"](#) table on page 2-89 for more information.

Certain specialty drugs have limits on the quantity that can be dispensed, as determined by Express Scripts. If your quantity is limited based on clinical guidelines or by an Express Scripts program, your copay amount may be prorated, as determined by Express Scripts.

Some prescriptions may require pre-service authorization, step therapy, or quantity limits

With most of your prescriptions, no pre-service authorization is necessary. However, some prescriptions require that you get authorization from Express Scripts in order to have the prescription covered by the plan. This pre-service authorization review must be conducted before the prescription can be filled and coverage provided under the prescription drug benefit. This pre-service authorization may also be referred to as pre-authorization, pre-approval, prior approval, prior authorization, pre-notification, pre-certification, or pre-auth. Many of the drug classes requiring pre-service authorization are listed starting on the next page. Contact Express Scripts to determine if your prescription requires pre-service authorization by visiting [express-scripts.com](https://www.express-scripts.com). Sign on and click **Prescriptions and Price a Medication** to search for your medication by name, or contact Express Scripts Member Services at 1-855-388-0352.

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 fill it through Express Scripts Home Delivery as described in this chapter. If pre-service authorization is necessary, your pharmacist or Express Scripts will let you know. If pre-service authorization is required, the provider who prescribed the medication must visit [esrx.com/PA](https://www.esrx.com/PA) or call 1-800-417-1764 to submit pertinent information to Express Scripts that is necessary for the pre-service authorization review. If you pay out-of-pocket for your prescription before obtaining the pre-service authorization and your pre-service authorization is approved thereafter, the plan will not be responsible for any cost above the contracted rate.

After the review is complete, Express Scripts will send you and your doctor a letter confirming whether coverage has been approved (usually within 48 hours after Express Scripts receives the information it needs).

If coverage is approved, you'll pay the applicable deductible, copay, or cost for your prescription as listed in the applicable [“What you'll pay for prescriptions: HRA-Based Medical Plan”](#) table on page 2-88, or in the [“What you'll pay for prescriptions: HSA-Based Medical Plan”](#) table on page 2-89. 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”](#)).

If you pay out of pocket for a prescription before obtaining the pre-service authorization and your pre-service authorization is approved thereafter, the plan will not be responsible for any cost above the contracted rate.

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” (meaning 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 either by law or according to the manufacturer's guidelines for use or by Express Scripts in its sole discretion. Drugs with quantity limits are also subject to pre-service authorization review.

List of drugs and conditions subject to pre-service authorization, step therapy, or quantity limits

The list of drugs and conditions below that require pre-service authorization or step therapy, or that may be subject to quantity limits, may change at any time without prior notice. As new prescription drugs, generic drugs, and additional information about existing drugs become available, they will be considered for coverage under the prescription drug benefit as they are introduced. For current information on medications that may require pre-service authorization, require step therapy, or have quantity limits, please contact Express Scripts. The following table provides information about many of the drug classes subject to these requirements.

Drug class or condition treated	Pre-service authorization required	Step therapy required	Quantity limits apply
Acne medications	X	X	
Acromegaly	X		
Alcohol and opioid dependency	X		
Allergies	X	X	X
Alzheimer's Disease	X	X	
Anabolic steroids	X		
Analgesics	X		
Anemia	X	X	
Antiandrogens	X		
Anticonvulsants	X	X	
Antiemetics (treat nausea and vomiting)	X		X
Anti-Infectives, IV and Nasal Rinse	X		
Anti-infectives, topical	X		X
Antifungals, topical	X		X
Antiobesity medications	X		
Asthma	X	X	X
Attention deficit hyperactivity disorder (ADHD)	X		
Beta blockers/Beta blocker combination	X	X	
Botulinum toxins	X		
Cancer treatments	X	X	
Cardiac disorder	X		
Carnitine deficiency agents	X		
Central precocious puberty (CPP)	X		
Cholesterol medications	X	X	
CNS – Huntington's disease	X		
Coagulation disorders (affect blood clotting)	X		
Contraceptives (when you can't use generic)	X	X	
Corticosteroids	X		
Cryopyrin-associated periodic syndromes (CAPS)	X	X	
Cushing's syndrome	X		
Cystic fibrosis	X		X
Depression	X	X	
Dermatology	X	X	
Diabetes medications	X	X	X
Duchenne Muscular Dystrophy (DMD agents)	X		
Electrolyte disorders	X		X
Emphysema	X		X

Drug class or condition treated	Pre-service authorization required	Step therapy required	Quantity limits apply
Enlarged prostate	X	X	
Fibrates	X	X	
Gastrointestinal disorders	X		
Gaucher disease	X	X	
Glaucoma	X	X	
Gout	X	X	
Growth hormone	X	X	
Hematopoietics	X		
Hemophilia	X		
Hepatitis C	X	X	X
Hereditary angioedema	X		
High blood pressure	X	X	X
Hormonal therapies	X		X
Idiopathic Pulmonary Fibrosis	X		X
Immune globulins	X		
Immune [Idiopathic thrombocytopenia purpura (ITP)]	X		
Influenza prevention			X
Interferon agents	X		
Iron overload	X		
Irritable bowel disease	X	X	
Kidney disorders	X		
Lipid disorders	X		
Lysosomal storage disease	X		
Metabolic Disorders	X		
Migraine medications	X	X	X
Movement disorders	X		
Multiple sclerosis	X	X	
Muscular dystrophy	X		
Narcolepsy	X	X	X
Nasal steroid combinations	X	X	
Neutropenia	X		X
NSAIDs	X	X	X
Ophthalmic anti-allergic	X	X	
Ophthalmic anti-inflammatory	X	X	
Ophthalmic Dry Eye Disease			X
Opioid analgesics and agonists	X	X	
Osteoarthritis	X		
Osteoporosis	X	X	X
Overactive Bladder			X
PAH Endothelin-receptor agonists	X	X	
Pain	X	X	X
Pancreatic enzymes	X	X	
Parkinson's disease	X		
Paroxysmal nocturnal hemoglobinuria (PNH) (red blood cell breakdown)	X		
Phenylketonuria (PKU)	X		

Drug class or condition treated	Pre-service authorization required	Step therapy required	Quantity limits apply
Pheochromocytoma		X	
Preterm birth	X		
Proton pump inhibitors	X	X	X
Psoriasis	X	X	
Pulmonary arterial hypertension	X	X	X
Pulmonary fibrosis	X		
Respiratory Epinephrine Auto-Injectors	X	X	X
Retinal disorders	X		
Rheumatoid arthritis	X	X	X
RSV (infant respiratory virus)	X		
Short-acting beta agonists	X		
Sleep agents	X	X	X
Systemic lupus erythematosus (SLE)	X		
Testosterone replacements	X		
Topical antiviral agents	X	X	
Topical immunomodulators	X		
Topical inflammatory conditions			X
Topical pain			X
Urea cycle disorders	X		
Urinary antispasmodics	X	X	
Wilson's Disease		X	

Prescriptions that are not covered

In addition to any other exclusions, limitations, and services listed as not covered as specified in this chapter, the prescription drug benefit does not cover the following (even if prescribed by a physician, or medically necessary):

- Compound drug ingredients as follows: proprietary base ingredients, including but not limited to PCCA Lipoderm Base, PCCA Custom Lipo-Max Cream, VersaBase Cream, VersaPro Cream, PCCA PracaSil Plus Base, Spirawash Gel Base, VersaBase Gel, Lipopen Ultra Cream, Lipo Cream Base, Pentravan Cream/Cream Plus, VersaPro Gel, Versatile Cream Base, PLO Transdermal Cream, Transdermal Pain Base Cream, PCCA Emollient Cream Base, Penderm, Salt Stable LS Advanced Cream, Ultraderm Cream, Base Cream Liposome, Mediderm Cream Base, and Salt Stable Cream.
- 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 are not approved for the method of administration, unless otherwise approved by Express Scripts based on clinical criteria as determined by Express Scripts in its sole discretion.
- Drugs that require administration by a dental professional (for example, Arestin or PerioChip).
- Drugs that treat hair loss, thinning hair, unwanted hair growth, or hair removal.
- Drugs or supplies that are not for your personal use or that of your covered dependent.
- Drugs whose intended use is illegal, unethical, imprudent, abusive, or otherwise improper.
- Drugs you purchase outside the U.S. that you are planning to use in the U.S.
- Early refills, except in certain emergency situations as approved by Express Scripts in its sole discretion. In these situations, you may receive up to a 30-day supply at a retail pharmacy or a 90-day supply from Express Scripts Home Delivery or from a CVS Pharmacy store. You'll be responsible for any copays or coinsurance amounts.
- High cost drugs in categories with suitable covered therapeutically equivalent products will not be covered by the plan regardless of medical necessity.
- Investigational or experimental drugs in original or compounded form, as determined by Express Scripts in its discretion.
- Mail order prescriptions that are not filled through Express Scripts Home Delivery.
- More than a 30-day supply of a prescription drug at a retail pharmacy, except when you have a prescription written for a 90-day supply and it is filled at a CVS Pharmacy store, even if there is not a CVS Pharmacy store in your area.
- New drugs or new formulations of drugs that have not been reviewed by Express Scripts for safety, efficacy, and cost-effectiveness unless approved by Express Scripts based on clinical criteria as determined by Express Scripts in its sole discretion.
- Non-sedating antihistamines.
- Nutritional supplements, dietary supplements, meal replacements, infant formula, or formula food products.
- Over-the-counter drugs or supplies, including vitamins and minerals or over-the-counter items that have been reformulated (except as may otherwise be required by applicable federal law).
- Prescriptions dispensed after one year from the original date of issue, more than six months after the date of issue for controlled substances, or prescriptions prohibited by applicable law or regulation.
- Prescription drug claims received beyond the 12-month timely filing requirement; Express Scripts must receive claims within 12 months of the prescription drug dispensed date.
- Prescriptions exceeding a reasonable quantity as determined by Express Scripts in its discretion.
- Prescriptions requested or processed after your coverage ends; you must be an active participant in the HRA-Based Medical Plan or the HSA-Based Medical Plan at the time your prescription is processed — not merely on the date your prescription is postmarked — for your prescription to be covered.

- Prescriptions that do not meet Express Scripts' coverage criteria.
- Prescriptions that do not meet the definition of a covered health service (see the "[Covered health services definition](#)" section on page 2-23).
- Replacement of lost or stolen medication.
- Specialty medications that are not filled through the required Accredo specialty pharmacy delivery.
- Sexual dysfunction drugs.
- Topical antifungal polishes (such as Penlac).

The following drugs are not covered by Express Scripts but may be covered by the medical coverage portion of your medical plan. Typically, these are administered in your doctor's office.

- Contraceptive devices and inserts that require fitting or application in a doctor's office, such as a diaphragm, or intrauterine devices (IUD).
- Prescription drugs that require administration under the direct supervision of a health care professional and are not acquired under the prescription drug benefits as described in this section.
- Immunization agents or vaccines (except Zostavax®, Gardasil, influenza vaccine, or Vivotif Berna).
- Therapeutic devices, appliances, and durable medical equipment, except for glucose monitors.

This list is subject to change. To determine if your prescription is covered, visit express-scripts.com, sign on, and click Prescriptions and Coverage. You may also contact Express Scripts Member Services at 1-855-388-0352.

Prescription drug coordination of benefits

The prescription drug benefit does not coordinate with other plans, including Medicare or Medicare Part D. This prescription drug benefit provides primary payment only and does not issue detailed receipts for submission to other carriers for secondary coverage. If another insurance company, plan, or program pays your prescription benefit first, there will be no payments made under this plan. Because there is no coordination of benefits provision for prescription drugs, you cannot submit claims to Express Scripts for reimbursement after any other payer has paid primary or has made the initial payment for the covered drugs.

If you or a covered dependent is covered under the HRA-Based Medical Plan or the HSA-Based Medical Plan, and Medicaid or other similar state programs for prescription drugs, in most instances, your prescription drug coverage under your medical plan at Wells Fargo is your primary drug coverage. You should purchase your prescription drugs using your Express Scripts ID card and submit out-of-pocket copay, deductible, or coinsurance expenses to Medicaid or other similar state programs.

Prescription drug claims and appeals

Express Scripts is the named claims and appeals fiduciary for the prescription drug claims and has sole and complete discretionary authority to determine the applicable claims and appeals in accordance with the terms of the documents or instruments governing the prescription drug benefits under the medical plans.

Filing a prescription drug claim

Urgent care claims

If the prescription drug benefit requires pre-service authorization to receive benefits and a faster decision is required to avoid seriously jeopardizing the life or health of the claimant, your physician must make the urgent care claim request by calling 1-800-753-2851. If you have questions, call customer service at 1-855-388-0352.

Important: Specifically state that your request is an urgent care claim.

Pre-service claims

If the prescription drug benefit requires pre-service authorization to receive benefits but is not considered an urgent care claim, your physician must submit the request for review electronically. Information about electronic options can be found at express-scripts.com/PA.

For questions about the pre-service authorization process, call 1-855-388-0352.

Post-service claims

You will need to file a claim if you buy prescription drugs or other covered supplies from a pharmacy not in the Express Scripts network or if the in-network pharmacy was unable to submit the claim successfully. All claims must be received by Express Scripts within 12 months from the date the prescription drug or covered supplies were dispensed. Claims not submitted within 12 months from the date the prescription drug or covered supplies were dispensed will not be covered.

Your out-of-network claim will be processed faster if you follow the correct procedures. Complete the Prescription Drug Reimbursement form and send it with the original prescription receipts. You may not use cash register receipts or container labels from prescription drugs purchased at an out-of-network pharmacy.

Prescription drug bills must provide the following information:

- Patient's full name
- Prescription number and name of medication
- Charge and date for each item purchased
- Quantity of medication
- Doctor's name

To get a claim form:

- Go to [express-scripts.com](https://www.express-scripts.com), log in, and download the claim form.
- Call Express Scripts Member Services at 1-855-388-0352 to request a form.

Send your claim to:

Express Scripts
Attn: Benefit Coverage Review Department
PO Box 66587
St. Louis, MO 63166-6587
Fax: 1-877-328-9660

You are responsible for any charges incurred but not covered.

Refer to “[Appendix A: Claims and Appeals](#)” for more information regarding claims.

Express Scripts claims questions, denied coverage, and appeals

If you have a question or concern about a claim already filed with Express Scripts, you may contact Express Scripts Member Services at 1-855-388-0352.

In the event your claim is denied (in whole or in part), you may also file a formal appeal under the terms of the Retiree Plan. A formal written appeal must be filed with Express Scripts within 180 days from the date you receive notification that your claim is denied, regardless of any verbal discussions that have occurred regarding your claim. (Exception: Urgent care claim appeals may be requested verbally.) Once you exhaust the internal appeals procedures, you may be entitled to an external review of your claim.

Complete information on appeals is provided in “[Appendix A: Claims and Appeals](#).”

Prescription drug right of recovery

For right of recovery provisions, refer to the “[Right of recovery](#)” section starting on page 2-83.

Other things you should know

Clinical Management Programs

Through a series of safety checks, Express Scripts clinical management programs help ensure that your prescription drug treatment is appropriate for your health situation. If these safety checks reveal a potential problem, an Express Scripts pharmacy professional or representative will directly contact your physician to review your treatment, and sometimes suggest a change to the current therapy.

Express Scripts will not change your medication without your doctor’s consent except for substituting a generic medication for a brand-name drug when a generic equivalent is available, where permitted by applicable law. If a suggested change is authorized, you will be notified by phone, letter, or both, all of which will contain the authorized change.

Express Scripts may contact your doctor about your prescription

Your prescription can be dispensed only as it is written by a physician or other lawful prescriber (as applicable to Express Scripts). Unless you or your doctor specifies otherwise, your prescription will be dispensed with the generic equivalent when available and if permissible by law (as applicable to Express Scripts).

You’re not limited to prescriptions on Express Scripts’ National Preferred Drug List, but you may pay less if you choose a drug from that list. If your doctor prescribes a drug that is not on the National Preferred Drug List but there’s an alternative on the list, Express Scripts may contact your doctor to see if that drug would work for you. However, your doctor always makes the final decision regarding your prescriptions. If your doctor agrees to prescribe a drug that is on the National Preferred Drug List instead of the drug that is not on the list, you will never pay more than you would have for the original prescription, and will usually pay less. Also, Express Scripts offers consultative services to help manage chronic or long-term conditions, such as diabetes. These services may help you save on pharmacy costs and may help to prevent related complications or disease progression. Through this program, you and your doctor may be contacted via telephone by an Express Scripts pharmacist to discuss your therapy and provide condition- and drug-specific counseling.

Prescription drug rebates

Express Scripts administers the prescription drug benefit on behalf of the Wells Fargo & Company Retiree Plan (“Retiree Plan”). The HRA-Based Medical Plan and the HSA-Based Medical Plan are components of the Retiree Plan. Express Scripts has negotiated certain rebates and discounts with participating retail pharmacies and drug manufacturers. For prescription drugs eligible for a rebate, the rebate may be taken into account in determining your cost-sharing when filling a prescription. The prescription drugs that may be eligible for a rebate and the rebate amount (if any) will change from time to time.

To the extent the Retiree Plan receives discounts or rebates based on Express Scripts’ negotiated rebates and discounts that exceed amounts taken into account in determining the out-of-pocket costs by Retiree Plan participants, such amounts will belong solely to the Retiree Plan and shall be held for the exclusive purpose of providing benefits to Retiree Plan participants and beneficiaries and defraying reasonable expenses of administering the Retiree Plan.

Chapter 3: Medical Plans for Retirees Eligible for Medicare

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Contacts

Information about the UnitedHealthcare Medicare Advantage Plan	1-800-430-5471 https://www.UHCretiree.com/wf
Information about Kaiser Medicare Advantage plans	1-800-443-0815 https://www.kp.org
Information about retiree medical coverage options	The Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1 https://benefitconnect.wf.ehr.com/ess

The basics

General information

Wells Fargo sponsors various retiree medical benefit options under the Wells Fargo & Company Retiree Plan (the Retiree Plan) for eligible retirees (and their eligible dependents) who are enrolled in Medicare Part A and Medicare Part B. The Retiree Plan is a retiree group health plan and is classified as a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA). The retiree medical benefit options may be referred to as retiree medical plans. If you (or your eligible dependents) are eligible for Medicare, you may be able to participate in one of the following retiree medical plan options:

- UnitedHealthcare Group Medicare Advantage (PPO) Plan (“UnitedHealthcare Group Medicare Advantage Plan”) designed especially for Medicare-eligible participants — you’ll receive separate documentation from UnitedHealthcare if you enroll. This plan option is insured by UnitedHealthcare.
- Kaiser Medicare Advantage plans designed especially for Medicare-eligible participants (available in California only) — you’ll receive separate documentation from Kaiser if you enroll. The Kaiser plan options are insured by Kaiser Permanente.

Note: The retiree medical plan option you elect may be referred to as your retiree medical plan or the retiree medical plan.

You must be enrolled in a retiree medical plan on the date of service to receive applicable benefits under that retiree medical plan.

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

If you are enrolled in one of the retiree medical plan options, you agree to give your health care providers permission to provide the applicable Medicare Advantage plan insurer access to required information about the care provided to you. The Medicare Advantage plan insurer 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 and pharmacy claims administrators, as permitted by law.

The Medicare Advantage plan insurer 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.

If you or your dependents are not yet eligible for Medicare, you are not eligible to be enrolled in the medical plans described in this chapter. For more information, refer to “[Chapter 1: Eligibility, Enrollment, and More](#)” and “[Chapter 2: Medical Plans for Retirees Not Yet Eligible for Medicare](#).”

Who’s eligible

For eligibility requirements for retiree medical coverage, refer to the following sections in “[Chapter 1: Eligibility, Enrollment, and More](#)”:

- “[Who’s eligible — retirees](#)”
- “[Who’s eligible — dependents](#)”

As noted in “[Chapter 1: Eligibility, Enrollment, and More](#)”, you will not be an eligible Medicare retiree under the Wells Fargo & Company Retiree Plan, even if you meet the other eligibility requirements, if you are not eligible for a subsidy as described in “[Appendix D: Retiree Group Tables](#)” or for a Retiree Medical Allowance Account (RMAA) as described in “[Chapter 4: Retirement Medical Allowance Account](#)” or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance. This exclusion does not apply to eligible Medicare retirees who were eligible for Medicare and enrolled in a Wells Fargo & Company Retiree Plan Medicare Advantage option with an effective date prior to April 1, 2018.

Residency within the U.S. is required to enroll and remain enrolled in retiree medical coverage, unless you resided in a U.S. territory and were enrolled in retiree medical coverage prior to January 1, 2020. Residency within the U.S. is not required for retirees who are eligible for and are currently enrolled in or enroll in the Retiree Medical Allowance Account (RMAA) as described in “[Chapter 4: Retirement Medical Allowance Account](#)” or in the Summary Plan Description for the Prudential Securities, Inc. Retirement Medical Allowance.

Only those enrolled in Medicare Part A and Medicare Part B are eligible to be enrolled in one of the Medicare Advantage medical plan options described in this chapter. If you or your covered dependent is approaching Medicare eligibility, you will need to initiate enrollment in Medicare Part A and Medicare Part B up to 90 days in advance to ensure that your Medicare coverage is effective as of your Medicare eligibility date. In addition, there are specific eligibility requirements imposed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare Advantage plans as follows:

- You must have a physical address within the U.S. or U.S. territories on file with Wells Fargo for purposes of the administration of Medicare Advantage coverage under the Retiree Plan. **Important Note:** Residency within the U.S. is required to enroll and remain enrolled in a Wells Fargo-sponsored Medicare Advantage plan, unless you resided in a U.S. territory and were enrolled in retiree medical coverage prior to January 1, 2020.

A PO Box is not considered a physical address. However, if you do not have a physical address because you live in a rural area or for some other reason, you may contact UnitedHealthcare or Kaiser, as applicable, to inquire about their attestation process. CMS may consider this attestation in lieu of a physical address when reviewing your application for enrollment in a Medicare Advantage plan.
- You and your covered dependent(s) must have a Medicare Beneficiary Identifier (MBI) on file with Wells Fargo for purposes of the administration of Medicare Advantage coverage under the Retiree Plan. Your MBI is the number that the Centers for Medicare & Medicaid Services assigns you when you enroll in Medicare. You can find it on your Medicare ID card.
- You cannot be incarcerated.
 - Any otherwise eligible dependent you want to cover cannot be incarcerated
- You may not be covered under a retiree medical plan as both a retiree and spouse or domestic partner, or a retiree and a dependent child at the same time.
- Additionally, you may not be covered under the retiree medical plan if you are covered under a medical plan option of the Wells Fargo Health Plan for active employees and their eligible dependents.

Rehired retirees

If you were eligible for a Wells Fargo-sponsored Medicare Advantage plan prior to April 1, 2018, but were not eligible for a retiree medical subsidy, should you be rehired by Wells Fargo and then re-retire at a future date, you (and any eligible dependents) will not be eligible for the Wells Fargo-sponsored Medicare Advantage plan. If you (and any eligible dependents) are Medicare-eligible and not eligible for a subsidy under the Plan, you will receive information about a voluntary Medicare coordinator service, Via Benefits. Via Benefits, and the plans it recommends, are not a part of the Wells Fargo & Company Retiree Plan.

How to enroll and when coverage begins

Refer to the “[How to enroll](#)” section in “Chapter 1: Eligibility, Enrollment, and More” for the time frame and general process for enrollment. Detailed information about the process for enrollment in the retiree medical plans described in this chapter is noted in the “[Medicare Advantage enrollment procedures](#)” starting on page 3-5 and “[Information about the UnitedHealthcare Temporary Medicare Supplement Plan](#)” starting on page 3-7.

After you have enrolled, coverage will begin under the Medicare Advantage plan once CMS approves your application. The effective date of coverage is determined by CMS and is generally the first of the month following the date you elected the Medicare Advantage coverage or the first of the month following the date you became eligible for Medicare benefits, whichever is later. If you do not provide a complete and accurate enrollment application prior to the end date of your previous coverage, you may experience a gap in coverage.

The UnitedHealthcare Temporary Medicare Supplement Plan may be available to provide coverage during the gap period. For information on eligibility for the UnitedHealthcare Temporary Medicare Supplement Plan, see the “[Information about the UnitedHealthcare Temporary Medicare Supplement Plan](#)” section, starting on page 3-7. Your request for coverage under this option is subject to approval by the Wells Fargo Retirement Service Center. If approved, your enrollment will generally be effective the first of the month following the date you elected the Medicare Advantage coverage or the first of the month following the date you became eligible for Medicare benefits, whichever is later.

Changing or canceling coverage

You may make limited 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 benefit elections](#)” section in “Chapter 1: Eligibility, Enrollment, and More.” You may cancel your coverage at any time, but you may never reenroll in a medical coverage option under the Retiree Plan in the future.

When coverage ends

Medical coverage for you or any enrolled dependents ends as described in the “[When coverage ends](#)” section in “Chapter 1: Eligibility, Enrollment, and More.”

In addition, the Centers for Medicare & Medicaid Services (CMS) does not allow you or a covered dependent to have more than one prescription drug plan at a time; enrollment in a Part D plan subsequent to enrollment in a Wells Fargo-sponsored Medicare Advantage plan will result in the termination of the Wells Fargo-sponsored Medicare Advantage coverage. If disenrolled from the Wells Fargo-sponsored Medicare Advantage plan as a result of your (or your covered dependent's) enrollment in an alternative prescription drug (Part D) plan, you (and/or your dependent) may not re-enroll in the Wells Fargo-sponsored plan in the future.

CMS also requires that coverage be terminated under a Medicare Advantage plan for any individual who is incarcerated.

- If you are covered under a Wells Fargo-sponsored Medicare Advantage plan and become incarcerated, you will be disenrolled from the plan on the first of the month following your incarceration.
 - If you become incarcerated and are disenrolled from the Medicare Advantage plan, you may not reenroll at any time in the future.
 - Coverage for any covered dependents under the Wells Fargo & Company Retiree Plan will also be terminated. COBRA continuation coverage will be offered to any dependents whose coverage was terminated due to your incarceration. For more information, see [“Appendix E: Continuing Coverage Under COBRA”](#) in this *Retiree Benefits Book*.
 - If you are eligible for a retirement medical allowance and applied it against the cost of your medical coverage under the Retiree Plan, and if you are disenrolled from the Medicare Advantage plan due to incarceration, your retirement medical allowance will be automatically allocated to a Retirement Medical Allowance Account (RMAA). For more information on an RMAA, see [“Chapter 4: Retirement Medical Allowance Account”](#) in this *Retiree Benefits Book*.
- If your covered dependent becomes incarcerated, your dependent will be disenrolled the first of the month following incarceration.
 - Once your dependent is no longer incarcerated, he or she may be reenrolled as your dependent under a Medicare Advantage option (if still offered under the Retiree Plan) within 60 days of an applicable Qualified Event, provided you are still enrolled in Wells Fargo-sponsored Medicare Advantage coverage, and your dependent continues to meet all eligibility requirements under the Retiree Plan.

Cost

Most retirees contribute to the cost of retiree medical coverage. For more information, refer to the [“Cost and funding”](#) section and the [“Payment of retiree coverage”](#) section in “Chapter 1: Eligibility, Enrollment, and More.”

Medicare overview

[“Chapter 1: Eligibility, Enrollment, and More”](#) includes important information about Medicare. Review the Medicare information carefully, as it may affect your ability to be enrolled in a retiree medical plan option.

Please see the [“Important information about enrollment in Medicare Part D”](#) section in “Chapter 1: Eligibility, Enrollment, and More” to learn whether or not enrollment in Medicare

Part D will result in your Wells Fargo-sponsored Medicare Advantage plan being terminated.

Note: If you or your dependents become eligible for Medicare for reasons other than turning 65, it is your responsibility to notify Wells Fargo by calling the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

Medicare Advantage plans

How Medicare Advantage plans work

Medicare Advantage plans are designed especially for retirees and covered dependents who are eligible for Medicare. If you enroll in a Medicare Advantage plan, you are required to assign your Medicare benefits to that plan. The Medicare Advantage plan then pays all claims for eligible covered health services according to the applicable Medicare Advantage plan provisions. (See below for more information about Medicare Advantage plans.) However, you pay 100% of the cost if you don’t use the Medicare Advantage plan’s doctors or facilities for medical services, or if you don’t follow your Medicare Advantage plan’s procedures.

Wells Fargo-sponsored Medicare Advantage plans

The following Medicare Advantage plans are available:

- UnitedHealthcare Group Medicare Advantage Plan, available nationwide
- Kaiser Medicare Advantage plans, available only in California

If you enroll in one of the Medicare Advantage plans, you will receive separate documentation from UnitedHealthcare or Kaiser, as applicable, after you enroll. Medicare Advantage plans cover the services that Medicare Part A and Medicare Part B cover. Additionally, the Wells Fargo-sponsored Medicare Advantage plans include prescription drug coverage, which is covered by Part D of Medicare. In exchange, your Medicare benefits are linked to your applicable Medicare Advantage plan coverage because the U.S. government has a contract with the Medicare Advantage plan to provide your Medicare benefits. When you assign your Medicare benefits to a Medicare Advantage plan, you agree you will not receive reimbursement by either your plan or Medicare for any services that aren’t covered by the plan, except for emergencies and Medicare Advantage plan referrals.

Medicare Advantage enrollment procedures

For you to participate in a Wells Fargo-sponsored Medicare Advantage plan, the Centers for Medicare & Medicaid Services (CMS) must approve your Medicare Advantage plan application. Visit <https://benefitconnect.wf.ehr.com/ess> or call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to elect a Medicare Advantage plan and start the application review process. Once you elect a plan online or by phone, your Medicare Advantage application will be forwarded to CMS. Your enrollment in the Medicare

Advantage plan only becomes effective following approval of your application by CMS. Processing your application typically takes 30 to 45 days. If your Medicare Advantage application is approved, the effective date of coverage is determined by CMS and is generally the first of the month following the date you elected the Medicare Advantage coverage or the first of the month following the date you became eligible for Medicare benefits, whichever is later.

CMS will not approve your application for enrollment in a Medicare Advantage plan if:

- You do not have a physical address within the U.S. or U.S. territories on file with Wells Fargo for purposes of the administration of Medicare Advantage coverage under the Retiree Plan. **Important Note:** Residency within the U.S. is required to enroll and remain enrolled in a Wells Fargo-sponsored Medicare Advantage plan, unless you resided in a U.S. territory and were enrolled in retiree medical coverage prior to January 1, 2020.

If you do not have a physical address on file upon electing a Medicare Advantage plan, you will be notified that a physical address must be provided within a specified time frame (generally, 21 days). A PO Box is not considered a physical address. However, if you do not have a physical address because you live in a rural area or for some other reason, you may contact UnitedHealthcare or Kaiser, as applicable, to inquire about their attestation process. CMS may consider this attestation in lieu of a physical address when reviewing your application for enrollment in a Medicare Advantage plan.

- You or any of your covered dependents do not have a valid Medicare Beneficiary Identifier (MBI) on file with Wells Fargo for purposes of the administration of Medicare Advantage coverage under the Retiree Plan. Your MBI is the number that the Centers for Medicare & Medicaid Services assigns you when you enroll in Medicare. You can find it on your Medicare ID card. If a valid MBI is not on file for you and each of your covered dependents upon electing a Medicare Advantage plan, you or your covered dependent who does not have a valid MBI on file will be notified that the MBI must be provided within a specified time frame (generally, 21 days). You must call your health plan (UnitedHealthcare or Kaiser) within the specified time frame and provide your MBI.
- CMS does not have a record of enrollment in Medicare Part A and Medicare Part B for you or any of your covered dependents. If CMS does not have a record of enrollment in Medicare Part A and Medicare Part B for you or any of your covered dependents upon electing a Medicare Advantage plan, the individual for whom CMS does not have a record of enrollment in Medicare Part A and Medicare Part B will be notified, and you must resolve this Medicare enrollment issue with CMS within a specified time frame (generally, 21 days). As stated previously, you or your covered dependent who is approaching Medicare eligibility should begin the Medicare application process up to 90 days prior to your Medicare effective date to ensure continuity of health care coverage.

You will not have coverage in the Wells Fargo-sponsored Medicare Advantage plan until CMS has approved your application. Therefore if your application is not accurate or complete, you may have a gap in coverage. If you had an extraordinary circumstance that prevented you from electing a Medicare Advantage plan or providing information requested by CMS in time to avoid a gap in coverage, you may request to be enrolled in coverage under the UnitedHealthcare Temporary Medicare Supplement Plan while your Medicare Advantage application is being reviewed by CMS by calling the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1. Your request for enrollment in the UnitedHealthcare Temporary Medicare Supplement Plan must be made within 30 days of the date on the notice from your health plan indicating that your application for enrollment in the Medicare Advantage plan was not approved. For more information, see the [“Information about the UnitedHealthcare Temporary Medicare Supplement Plan”](#) section starting on page 3-7. This temporary plan applies for Kaiser and UnitedHealthcare Medicare Advantage Plan applicants.

Changing from one Medicare Advantage plan to another

Please follow the instructions for enrolling in a Medicare Advantage plan. It is not necessary to complete a Medicare Advantage plan disenrollment application. Remember that your retiree medical plan election remains in effect the entire year and cannot be changed unless you notify the Wells Fargo Retirement Service Center within 60 days of a Qualified Event that permits a change in retiree medical plan options or during Annual Benefits Enrollment.

Medicare Advantage plans in the individual market

Several Medicare Advantage plans are offered in the individual market. These Medicare Advantage plans have different administrative rules, costs, and benefits than those sponsored by Wells Fargo. These plans should not be confused with the Wells Fargo-sponsored Medicare Advantage plans. If you enroll in a plan through an individual insurance company at any time (when you are initially eligible for retiree medical coverage, during annual benefits enrollment, or at any point mid-year), your Wells Fargo retiree medical coverage will be terminated and you may never reenroll in a retiree medical plan option sponsored by Wells Fargo. You will also lose your Wells Fargo subsidy, if applicable.

Information about the UnitedHealthcare Temporary Medicare Supplement Plan

This section only provides general information about eligibility for and enrolling in the UnitedHealthcare Temporary Medicare Supplement Plan. After you are enrolled in the UnitedHealthcare Temporary Medicare Supplement Plan, you will receive a separate Summary Plan Description booklet, from Wells Fargo, describing the benefits provided and other important information about the plan option.

Enrollment in the UnitedHealthcare Temporary Medicare Supplement Plan is temporary and is designed to provide short-term coverage for you and any of your covered dependents. The UnitedHealthcare Temporary Medicare Supplement Plan does not provide coverage for participants who have not yet initiated enrollment in Medicare Part A and Medicare Part B and are waiting for an opportunity to enroll. If you are Medicare eligible, you must have initiated enrollment on a timely basis in Medicare Part A and Medicare Part B in order to enroll in any medical plan option under the Retiree Plan. Generally, you should begin the application for Medicare Part A and Medicare Part B as many as 90 days before the month in which you become Medicare eligible. This helps ensure you will not experience a gap in coverage.

Additionally, the UnitedHealthcare Temporary Medicare Supplement Plan is only a plan option if you have requested enrollment in a Wells Fargo-sponsored Medicare Advantage plan and one of the events listed below has occurred. The Plan Administrator will review the applicable facts and circumstances and will determine in its sole discretion whether one of the following events occurred:

- You experienced an extraordinary circumstance that prevented you from electing a Medicare Advantage plan in time to avoid a gap in coverage.^{1,2} Your extraordinary circumstance will be evaluated by the plan administrator or its designee.
- You have been notified that CMS has reviewed your application for the Group Medicare Advantage Plan and identified information that you must provide or correct before CMS can approve your application.^{1,3,4}

- Your application for enrollment was not sent or processed due to an administrative error outside of your control.^{1,2,4}

1. Once your coverage under the Medicare Advantage plan becomes effective, coverage under the UnitedHealthcare Temporary Medicare Supplement Plan will be terminated. Any amounts that accumulated toward your out-of-pocket maximum while enrolled in the UnitedHealthcare Temporary Medicare Supplement Plan will not apply to the Wells Fargo-sponsored Medicare Advantage plan.
2. If CMS does not approve your Medicare Advantage application, coverage under the UnitedHealthcare Temporary Medicare Supplement Plan will be terminated.
3. For examples of the types of information that could cause a delay in CMS approving your Medicare Advantage application, see the "[Medicare Advantage enrollment procedures](#)" section starting on page 3-5.
4. If you do not take action to provide the information required by CMS for enrollment in a Medicare Advantage plan by the specified deadline or if CMS does not approve your application for enrollment, coverage under the UnitedHealthcare Temporary Medicare Supplement Plan will be terminated and you cannot reenroll in a retiree medical plan under the Retiree Plan at any time in the future. Coverage for any eligible dependents will also be terminated and they will be unable to enroll in the future.

If you have experienced one of the above-described events, you must call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1, to request temporary enrollment in the UnitedHealthcare Temporary Medicare Supplement Plan. Your request for enrollment in the UnitedHealthcare Temporary Medicare Supplement Plan must be made within 30 days of the date on the notice from your health plan indicating that your application for enrollment in the Medicare Advantage plan was not approved.

If you are dissatisfied with the determination you received from the Wells Fargo Retirement Service Center, you may submit a written request for a review of your situation to Corporate Benefits at the following address:

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

Corporate Benefits cannot accept requests sent by fax or email. Before you send a request to Corporate Benefits for review, the Wells Fargo Retirement Service Center must have already reviewed your request. Corporate Benefits must receive your request for review within 30 days of the date that the Wells Fargo Retirement Service Center denied your request. Any requests received after 30 days will not be reviewed.

Wells Fargo Corporate Benefits has sole and complete discretionary authority to make decisions relating to eligibility for enrollment in the retiree medical plans, subject to the terms of applicable plan documents. Decisions by Wells Fargo Corporate Benefits on all enrollment issues are conclusive and binding.

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Chapter 4: Retirement Medical Allowance Account

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Contacts

Information about the Retirement Medical Allowance Account	HealthEquity 1-877-924-3967
To email claims	paymeback@wageworksclaims.com
To fax claim forms toll-free	1-877-353-9236
To file claims online, view account information, access Statement of Activity, or find forms	https://participant.wageworks.com
Information about eligibility	The Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1 benefitconnect.wf.ehr.com/ess

The information in this chapter — along with applicable sections of [“Chapter 1: Eligibility, Enrollment, and More,”](#) [“Appendix A: Claims and Appeals,”](#) [“Appendix B: Important Notifications and Disclosures,”](#) and [“Appendix E: Continuing Coverage Under COBRA”](#) in this *Retiree Benefits Book* — constitutes the Summary Plan Description (SPD) for the Retirement Medical Allowance Account (RMAA). However, the retiree eligibility requirements stated in [“Chapter 1: Eligibility, Enrollment, and More”](#) do not apply. To determine if you are a retiree eligible for an RMAA, see the “Who’s eligible” section on this page.

The basics

General information

The RMAA is part of the Wells Fargo & Company Retiree Plan (Retiree Plan). An RMAA is an account set up to allow reimbursement of eligible health care expenses that you and your eligible dependents incur that are not covered or reimbursed by another benefit plan or account. If you are an eligible retiree, you may elect to apply your annual retirement medical allowance to an RMAA. (To determine whether you’re an eligible retiree, see the “Who’s eligible” section on this page.) After you’ve made this election, Wells Fargo will determine your retirement medical allowance each plan year and allocate that amount to an individual bookkeeping account set up in your name.

RMAA claims may be paid from Wells Fargo’s general assets or from a trust fund established to fund benefits under the Retiree Plan, to which Wells Fargo may also make contributions. 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 Retiree Plan purposes. Nothing requires that amounts deposited to a trust fund be held separately or used for a particular benefit option, including the RMAA. No retiree, participant, dependent, or beneficiary will have any right to, or interest in, amounts allocated to an RMAA, including amounts held in a trust fund, until reimbursement of eligible health care expenses is actually made.

Note: For the purposes of this chapter describing the RMAA, the plan year is the same as a calendar year, beginning on January 1 and ending the following December 31.

You can use an RMAA to receive reimbursement for eligible health care expenses such as copays, orthodontia, or eyeglasses, and eligible over-the-counter medications for you or your eligible dependents who are not covered or reimbursed by another benefit plan or account. For more information, go to <https://participant.wageworks.com>, sign on to your account, and navigate to Eligible Expenses.

Balances do not roll over from plan year to plan year, so if there’s a balance remaining in your previous plan year account after the April 30 claims filing deadline, you’ll forfeit the remaining balance. For example, if you have not filed for reimbursement of your eligible 2020 expenses by April 30, 2021, any remaining 2020 funds will be forfeited.

Claims administrator

HealthEquity is the claims administrator for the RMAA and will determine eligibility of all expenses.

Who’s eligible

Eligibility

You are eligible for an RMAA if you satisfy one of the eligibility criteria in the Eligibility criteria section starting on this page, and you met one of the following requirements as of December 31, 2009:

- You had an RMAA.
- You had a retirement medical allowance and elected coverage under a Wachovia retiree medical plan option (your retirement medical allowance was used to offset the cost of coverage).
- You deferred your election of an RMAA or coverage under a retiree medical plan option.

Retirees and their eligible dependents are not eligible to have more than one RMAA or receive any other form of retiree medical coverage or retiree medical subsidy under the Retiree Plan. Your RMAA is based on your years of service on your last day of employment and your age as described in the [“Amount of annual retirement medical allowance allotted to RMAAs”](#) section starting on page 4-6.

Eligibility criteria

The groups described below are eligible for a retirement medical allowance that can be used to offset the cost of retiree medical coverage and **cannot** be applied to an RMAA:

1. You were an employee of **The Money Store** and retired prior to April 1, 1999.
2. You were an employee of **Wachovia Corporation** and retired between January 1, 2001, and January 1, 2002.
3. You were an employee of **First Fidelity** and retired between July 1, 1992, and January 1, 1996, and your age plus years of service did not equal 75.

If you satisfy one of the following eligibility criteria, you are eligible for an RMAA, but only if you retired on or before January 1, 2008.

1. You are currently enrolled in an RMAA.
2. You are eligible for an RMAA if you retired from active employment from **Wachovia** as an Eligible Employee after January 1, 2002, and on or before December 31, 2007, with the exception of former Golden West Financial employees who retired from active employment with Wachovia as Eligible Employees:
 - On or after reaching your 65th birthday and completing at least five years of service; and you have been continuously covered under the plan since your retirement date
 - After reaching age 50 and completing 10 years of service, and you have been continuously covered under the plan since your retirement date

3. You also are eligible for an RMAA if you retired from **First Union Corporation** between February 1, 1992, and December 31, 2001, and you have been continuously covered under the plan since your retirement date.

4. You also are eligible for an RMAA if:

- You terminated employment as an Eligible Employee from **First Union Corporation** in connection with the Restructuring Group or the 2000 Strategic Initiative Group (and, if part of the Restructuring Group, you continued in employment until the “stay date” communicated to you)
- You have reached age 45 or will do so by the end of the calendar year in which you cease to accrue a benefit under the Wachovia Pension Plan
- You have accrued 20 years of service under the Wachovia Pension Plan

5. You also are eligible for an RMAA if you satisfy all conditions of the following “Rule of 65”:

- You were displaced or divested¹ as an Eligible Employee between September 1, 2001, and December 31, 2007
- You are not a former Golden West Financial employee
- You were at least age 45 at time of displacement or divestiture
- You have completed at least one year of service
- Your years of service plus age, at time of displacement or divestiture, equal at least 65²

1. “Displaced” means any termination of employment that was designated as a displacement by Wachovia Corporation and was so identified on Wachovia’s databases and that arose on or after September 1, 2001. “Divested” means any termination of employment on or after September 1, 2001, with Wachovia Corporation (or any other employer participating in Wachovia’s Retiree Health and Welfare Plan) through the sale or disposition of Wachovia’s (or such participating employer’s) assets, or through the sale or disposition of a division or subsidiary of Wachovia (or such participating employer) and identified as a divestiture on Wachovia’s (or such participating employer’s) databases.

2. If you were a participant in the Retirement Income Plan of Wachovia Corporation and were displaced or divested from September 1, 2001, through December 31, 2004, and total service (according to your company service date) is greater than vesting service as of December 31, 2001, then the adjusted total service through December 31, 2001, plus service earned after December 31, 2001, will be used in order to allow eligibility for the Rule of 65.

6. You also are eligible for an RMAA if you retired from:

- **Wheat First Securities** and the last day of your benefits continuation period expired on or after June 30, 1998; and you have been continuously covered under the plan since the last day of your benefits continuation period. For purposes of this paragraph, your “benefits continuation period” means the period during which you were eligible to continue coverage under the First Union Corporation Group Health Care Plan (or as later amended and restated as the Wachovia Corporation Health and Welfare Plan) pursuant to a severance agreement made in connection with the First Union Corporation Severance Pay Plan (or as later amended and restated as the Wachovia Corporation Severance Pay Plan).

- The **Money Store** between April 1, 1999, and July 1, 1999, and the last day of your benefits continuation period expired on or after April 1, 1999; and you have been continuously covered under the plan since the last day of your benefits continuation period. For purposes of this paragraph, your “benefits continuation period” means the period during which you were eligible to continue coverage under the First Union Corporation Group Health Care Plan (or as later amended and restated as the Wachovia Corporation Health and Welfare Plan) pursuant to a severance agreement made in connection with the First Union Corporation Severance Pay Plan (or as later amended and restated as the Wachovia Corporation Severance Pay Plan).

7. You also are eligible for an RMAA if:

- You were an employee of **Signet Bank** on December 31, 1997
- You retired between January 1, 1998, and October 1, 1998, and elected a Retirement Medical Allowance or Account, or you retired after October 1, 1998
- You have been continuously covered under the plan since your retirement date

8. You also are eligible for an RMAA if:

- You were a former employee of **CoreStates Bank** and retired during the CoreStates Window Period between January 1, 1999, and December 31, 2001
- You elected a Retirement Medical Allowance or Account on your retirement date
- You have been continuously covered under the plan since your retirement date

9. You also are eligible for an RMAA if:

- You were an employee of **EVEREN Capital Corporation** on September 30, 1999, and retired between October 2, 1999, and December 31, 2001
- You elected a Retirement Medical Allowance or Account on your retirement date
- You have been continuously covered under the plan since your retirement date

10. You also are eligible for an RMAA if:

- You were an employee of **Prudential Securities Inc. (PSI)** on December 31, 2003, and you retired between February 1, 2004, and December 31, 2005; and all of the following are true:
 - Your age plus years of service equal 75 (as determined by the plan administrator in accordance with the plan’s internal policies and procedures)
 - You elected a Retirement Medical Allowance or Account on your retirement date
 - You have been continuously covered under the plan since your retirement date

- You were an employee of **SouthTrust** on December 31, 2004, and you retired after February 1, 2005; and all of the following are true:
 - Your age plus years of service equal 75 (as determined by the Plan Administrator in accordance with the plan's internal policies and procedures)
 - You elected a Retirement Medical Allowance or Account on your retirement date
 - You have been continuously covered under the plan since your retirement date

11. You also are eligible for an RMAA if:

- You were an employee of **SouthTrust Corporation** ("SouthTrust") on December 31, 2004, and you retired between February 1, 2005, and December 31, 2006
- You elected a Retirement Medical Allowance or Account on your retirement date
- You have been continuously covered under the plan since your retirement date

Retirees not eligible for an RMAA

If you do not meet the eligibility as previously stated, you are not eligible for an RMAA.

Special note regarding the Prudential Securities Inc. Retirement Medical Allowance (PSI RMA)

This chapter does not apply to the PSI RMA. Please refer to the Prudential Securities Inc. Retirement Medical Allowance Summary Plan Description. To receive a copy of the PSI RMA Summary Plan Description, you may call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

Coverage under a retiree medical plan option

If you are eligible for an RMAA, elected to apply your retirement medical allowance against the cost of your coverage under a Wells Fargo & Company retiree medical plan option, and you drop your coverage under the retiree medical plan option during Annual Benefits Enrollment or a midyear Qualified Event, your retirement medical allowance will be automatically allocated to an RMAA. Please note that after you drop your coverage under a Wells Fargo & Company retiree medical plan option, you cannot reenroll in a Wells Fargo & Company retiree medical plan option in the future. If your retiree medical coverage is terminated for nonpayment of premiums, you will not be eligible for an RMAA.

Deferred elections

If you deferred your election of an RMAA or coverage under a retiree medical plan option, contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1 to make an election. You can elect to (1) apply your retirement medical allowance to the cost of coverage under a Wells Fargo & Company retiree medical plan option, or (2) have your retiree medical allowance credited to an RMAA. Elections will generally be effective the first of the month following election notification. However, for you to participate in a Wells Fargo-sponsored Medicare Advantage plan, the Centers for Medicare & Medicaid Services (CMS) must approve your Medicare Advantage plan application. Once you elect a plan online or by phone, your Medicare Advantage application will be forwarded to CMS. Your enrollment in the Medicare Advantage plan only becomes effective following approval of your application by CMS. Processing your application typically takes 30 to 45 days. If your Medicare Advantage application is approved, the effective date of coverage is determined by CMS and is generally the first of the month following the date you elected the Medicare Advantage coverage or the first of the month following the date you became eligible for Medicare benefits, whichever is later. Such elections are contingent on Wells Fargo continuing to sponsor retiree medical plan options or allow deferred elections.

If you deferred your election at the time of your retirement and if you were eligible for a retirement medical allowance at the time of your death, your eligible dependents will have an opportunity to elect to participate in an RMAA, to participate in a retiree medical plan option, or to defer their election, as long as they elect coverage within one year of your death. Your eligible dependents will be eligible to receive 100% of your retirement medical allowance to contribute to an RMAA or apply toward the cost of coverage for a retiree medical plan option for as long as Wells Fargo continues to provide the allowance and sponsor the retiree medical plan options. Elections will be effective the first of the month following election notification. Such elections are contingent on Wells Fargo continuing to sponsor retiree medical plan options or allow deferred elections.

Eligible dependents

If you are an eligible retiree who has elected to have your retirement medical allowance allocated to an RMAA, your RMAA can be used to reimburse qualified 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 children*
- Your qualifying relatives*

* Special rules may allow a dependent's expense to be eligible for reimbursement under the RMAA even when that dependent cannot be claimed as your tax dependent on your tax return form. You should consult with a tax advisor regarding any tax implications.

RMAA, taxes, and rules you should know

Allocations to and reimbursements from the RMAA are designed to qualify for favorable tax treatment by the IRS. That means that you won't pay federal income tax or employment tax (and in most states, state income tax) on the money in your RMAA, or on any reimbursement you receive from that account. You should consult with a tax advisor regarding any tax implications.

In exchange for these potential tax advantages, the IRS imposes strict rules about how you may use the RMAA. Before enrolling, consider the rules described below. The information provided in this chapter is not intended to provide tax advice for any individual's specific situation. If you have any questions regarding the tax implications surrounding your specific situation, consult with a tax advisor.

- You can't deduct expenses paid by the RMAA on your tax returns, nor can you claim a tax credit for them.
- You must use the money for eligible expenses that are incurred in the same year the money was allocated. You can't be reimbursed for expenses incurred before your participation begins or after your participation ends.
- An expense is incurred when the service is received, not when payment is made.
- You must submit claims to HealthEquity with proper expense documentation for the current year's incurred eligible expenses by April 30 of the following year. Claims or expense documentation submitted after the deadline will not be reimbursed.
- Your request for reimbursement and the supporting documentation must be postmarked by April 30 the year following the plan year in which you incurred the expense for the expense to be eligible for reimbursement.
- If the April 30 claims submission deadline has passed and you have a balance in the RMAA after all requests for reimbursement postmarked by April 30 have been processed, 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. Forfeited balances may be applied toward payment of the RMAA's administrative expenses, to provide benefits under the Retiree Plan, or for any purpose permitted by applicable law.

Amount of annual retirement medical allowance allotted to RMAAs

The amount of the annual retirement medical allowance will vary depending upon your years of service and your age as of your last day of employment (as described in more detail below). If you enroll in an RMAA midyear or if you turn age 65 midyear and are enrolled in an RMAA, the retirement medical allowance will be prorated for the number of months remaining in the calendar year.

Wells Fargo reserves the right to change the amount or calculation of the retirement medical allowance and the right to terminate the retirement medical allowance at any time, for any reason, with or without notice.

20 or more years of service on your last day of employment

If you had 20 or more years of service on your last date of employment, your annual retirement medical allowance was calculated, before January 1, 2017, using the number of complete years of service you had earned multiplied by either:

- \$55, if you were age 65 or older on your last date of employment
- \$60, if you were under age 65 on your last date of employment
 - If you turned 65 before January 1, 2017, upon turning age 65 your complete years of service were multiplied by \$55 to determine your annual, or prorated, retirement medical allowance

Effective January 1, 2017, for individuals who are 65 or who turn 65 after January 1, 2017, your annual retirement medical allowance will be recalculated as follows:

- Complete years of service multiplied by \$55
- Divided by 12
- Rounded up to the nearest \$25 increment
- Reduced by 40%
- Multiplied by 12

Example

Assume you were age 59 with 30 years of service on your last day of employment, which was September, 1, 2007, and turned 65 on June 15, 2013.

First year of retirement: From September 1, 2007, through December 31, 2007, your annual retirement medical allowance was \$600:

$$\frac{30 \text{ years} \times \$60}{12 \text{ months}} \times 4 \text{ months}$$

Second year of retirement through year prior to turning age 65: From January 1, 2008, through December 31, 2012, your annual retirement medical allowance was \$1,800:

$$\frac{30 \text{ years} \times \$60}{12 \text{ months}} \times 12 \text{ months}$$

For the year in which you turn age 65: From January 1, 2013, through December 31, 2013, since you turned 65 in June 2013, your retirement medical allowance was adjusted to \$1,712.50:

$$\left(\frac{30 \text{ years} \times \$60}{12 \text{ months}} \times 5 \text{ months} \right) + \left(\frac{30 \text{ years} \times \$55}{12 \text{ months}} \times 7 \text{ months} \right)$$

For the year after you turn age 65 through 2016: From January 1, 2014, through December 31, 2016, your retirement medical allowance was adjusted to \$1,650.00:

$$\frac{30 \text{ years} \times \$55}{12 \text{ months}} \times 12 \text{ months}$$

As of January 1, 2017, because you are over age 65, your retirement medical allowance is adjusted to \$1,080:

- 30 years of service x \$55 = \$1,650
- \$1,650 divided by 12 = \$137.50
- \$137.50 rounded up to the next \$25 increment = \$150
- \$150 reduced by 40% (\$60) = \$90
- \$90 x 12 months = \$1,080 annual retirement medical allowance

Less than 20 years of service on your last day of employment

If you had less than 20 years of service on your last date of employment, your annual retirement medical allowance was calculated, before January 1, 2017, using the number of complete years of service you had earned multiplied by \$42.

Effective January 1, 2017, for individuals who are 65 or who turn 65 after January 1, 2017, your annual retirement medical allowance will be recalculated as follows:

- Complete years of service multiplied by \$42
- Divided by 12
- Rounded up to the nearest \$25 increment
- Reduced by 40%
- Multiplied by 12

Example

Assume you were age 59 with 15 years of service on your last day of employment, which was September, 1, 2007, and turned 65 on June 15, 2013.

First year of retirement: From September 1, 2007, through December 31, 2007, your annual retirement medical allowance was \$210:

$$\frac{15 \text{ years} \times \$42}{12 \text{ months}} \times 4 \text{ months}$$

Second year of retirement through 2016: From January 1, 2008, through December 31, 2016, your annual retirement medical allowance was \$630:

$$\frac{15 \text{ years} \times \$42}{12 \text{ months}} \times 12 \text{ months}$$

As of January 1, 2017, because you are over age 65, your retirement medical allowance is adjusted to \$540:

- 15 years of service x \$42 = \$630
- \$630 divided by 12 = \$52.50
- \$52.50 rounded up to the next \$25 increment = \$75
- \$75 reduced by 40% (\$30) = \$45
- \$45 x 12 months = \$540 annual retirement medical allowance

Calculating service

Your eligibility for receiving a retirement medical allowance is based in part on your years of service. For purposes of this SPD, you earned one year of service for each calendar year in which you were employed at Wachovia, starting with your hire date, and were credited with at least 1,000 hours of service. However, you did not accumulate years of service during any period in which you were not an eligible employee. Also, if you were an eligible employee with certain merger groups, you may have received credit for service from that employer that may also be included in your years of service.

If, when you were an eligible Wachovia employee, you were scheduled to work 40 hours or more per week, you were credited with 190 hours of service for each month in which you worked one hour, or the actual hours worked in the month if actual hours were greater than 190 hours.

If, when you were an eligible Wachovia employee, you were scheduled to work less than 40 hours per week, you were credited for an hour of service for each hour that you worked.

As an eligible employee, you also earned an hour of service, just as if you were at work, for each hour you were paid during:

- Holidays and Paid Time Off (PTO)
- Disability
- Jury duty
- Military duty
- A paid leave of absence
- Maternity or paternity leave (after December 31, 1984)
- Pregnancy
- Birth of a child
- Adoption of a child
- Caring for a child immediately following birth or placement
- Certain back pay awards
- Salary Continuation Leave (after January 1, 2009)

However, you would not have been credited with more than 501 hours of service during any single continuous period away from your job.

Special eligibility and service credit rules for former employees of Hewitt Associates

If you met all of the following criteria:

- You worked for Hewitt Associates (“Hewitt”)
- You were employed by Wachovia immediately before your employment with Hewitt
- You were rehired by Wachovia to perform work that was previously outsourced to Hewitt

You received service credit for service with Hewitt for purposes of determining years of service, provided that you:

- Were working at Hewitt on the Wachovia account either immediately before your hire date or within the 12 months preceding your hire date
- Accepted a position with Wachovia to perform work that was previously outsourced to Hewitt
- Were hired by Wachovia on or after April 15, 2008, and before March 31, 2009

This also applies to certain former employees of Hewitt who were hired by Wachovia to perform work that was previously outsourced to Hewitt.

You did not earn hours of service when you took time away from work and were receiving payments due to:

- Workers’ compensation
- Unemployment
- Disability insurance laws
- Reimbursement for medical expenses
- PTO taken as a lump-sum payment

How to enroll

If you are eligible to receive a retirement medical allowance, you have the following enrollment election options:

- If you are currently enrolled in an RMAA, no further action is required to stay enrolled.
- If you are currently enrolled in a Wells Fargo & Company retiree medical plan option and eligible for the RMAA, each year during Annual Benefits Enrollment, you can elect to drop your retiree medical plan option and enroll in the RMAA. After you cancel your coverage under a Wells Fargo & Company retiree medical plan option, you cannot reenroll in any Wells Fargo & Company retiree medical plan option in the future. If your retiree medical coverage is terminated for nonpayment of premiums, you will not be eligible for an RMAA.
- If you deferred your retirement medical allowance, you can contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1 to activate your election.

If you are eligible and you elect to apply the retirement medical allowance to an RMAA, the election is irrevocable. You will no longer have annual enrollment elections, nor will you be able to reenroll in a Wells Fargo & Company retiree medical plan option at a later date.

Regardless of when you make your initial enrollment election, the effective date for participation will be the first of the month following the month in which you made your election. For example, if you retired on March 1, 2007, and you defer making an election to participate in an RMAA until May 15, 2010, your participation will become effective on June 1, 2010.

When participation ends

Participation in the RMAA ends if Wells Fargo stops providing the RMAA, or on the date that:

- You are rehired by Wells Fargo & Company (or an affiliate of Wells Fargo & Company).
- You no longer meet the eligibility requirements for the RMAA.
- You end participation in the RMAA.
- You are deceased (see the “Elections for survivors” section starting on the next page).
- You have an RMAA as a survivor and become eligible for an RMAA as a retiree. Your RMAA as a retiree will replace your RMAA as a survivor.

As with any other benefit, Wells Fargo reserves the right to review, change, interpret, or terminate this benefit at any time without prior notice. For more information on the RMAA’s amendment and termination procedures, see the [“Future of the plans”](#) section in “Appendix B: Important Notifications and Disclosures.”

If you are rehired by Wells Fargo

If you retired and are rehired by Wells Fargo on or after January 1, 2011, your participation in the RMAA will cease.

When you retire again

If, after you are rehired, you retire again, your previous annual retirement medical allowance amount and applicable RMAA will be reinstated, based on your election prior to being rehired, as long as Wells Fargo continues to provide the retirement medical allowance and RMAA to eligible retirees. If you were not enrolled in a Wells Fargo & Company retiree medical plan option at the time you were rehired, you cannot enroll in a retiree medical plan option when you re-retire.

If you were in a deferral status, you may elect to apply your available retirement medical allowance against the cost of your coverage under a Wells Fargo & Company retiree medical plan option or you may elect to have it fund an RMAA. If you elect to apply your retirement medical allowance against the cost of your coverage under a Wells Fargo & Company retiree medical plan option, you drop your coverage under the retiree medical plan

option during Annual Benefits Enrollment or a midyear Qualified Event, and you are eligible for an RMAA, your retirement medical allowance will be contributed to an RMAA. Please note that after you drop your coverage under a Wells Fargo & Company retiree medical plan option, you cannot reenroll in the future.

Elections for survivors

If you die while you are either a participant in the RMAA, have a deferred election, or were covered under a Wells Fargo & Company retiree medical plan option and had a retirement medical allowance, your eligible surviving dependents who survive you may make the following elections, as applicable, as long as they elect coverage within one year of your death:

- If you participate in an RMAA at the time of your death, your eligible surviving dependents will have an opportunity to elect to participate in the RMAA.
- If you deferred your retiree benefit election and were eligible for a retirement medical allowance and RMAA at the time of your death, your eligible surviving dependents will have an opportunity to elect one of the following options:
 - Participate in the RMAA
 - Participate in a Wells Fargo & Company retiree medical plan option
- If you cover yourself and your dependents under a Wells Fargo & Company retiree medical plan option, have a retirement medical allowance, and are eligible for an RMAA at the time of your death, your eligible surviving dependents will have an opportunity to elect one of the following options:
 - Continue their Wells Fargo & Company retiree medical plan option, as provided under the Retiree Plan and in effect immediately preceding your death
 - Participate in the RMAA
- If you cover yourself only under a Wells Fargo & Company retiree medical plan option, have a retirement medical allowance, and are eligible for an RMAA at the time of your death, your eligible surviving dependents will have an opportunity to elect to participate in the RMAA.

Your eligible surviving dependents are those who qualify as your eligible spouse, eligible domestic partner, eligible dependent children, or eligible dependent relatives, as described in the [“Eligible dependents”](#) section on page 4-5, immediately preceding your death. Eligible surviving dependents are not eligible to have more than one RMAA or receive any other form of retiree medical coverage or retiree medical subsidy under the Retiree Plan. Therefore, eligible surviving dependents with retiree medical coverage or an RMAA as a retiree are not eligible for your retirement medical allowance as a survivor.

Your eligible surviving dependents will be eligible to receive 100% of your retirement medical allowance to contribute to an RMAA, if eligible, or to apply toward the cost of medical coverage. The retirement medical allowance calculation is based on the retiree's date of birth. (See the [“Amount of annual retirement medical allowance allotted to RMAAs”](#) section starting on page 4-6.)

Eligible surviving dependents with retiree medical coverage (that is, as a retiree, not as an eligible surviving dependent) may drop their retiree medical coverage during Annual Benefits Enrollment or for a midyear Qualified Event and may enroll in the RMAA as an eligible surviving dependent.

If your surviving eligible spouse or domestic partner elects an RMAA, the allowance amount will be allocated in full to an RMAA in their name. In the absence of a surviving eligible spouse or domestic partner, the allowance amount will be allocated in full to a single RMAA for your combined eligible surviving dependents. Only the qualified expenses of your survivors who are surviving eligible dependents at the time of your death may be reimbursed from the eligible surviving dependents' RMAA.

Participation for surviving dependents will end on the earlier of the following:

- The date of the death of the surviving dependent
- The date the individual is no longer an eligible dependent
- The end of the month that your eligible dependent child or children turn age 26

Dependent eligibility is subject to the terms and conditions described in this SPD (including Wells Fargo's expressly reserved right to amend, modify, or terminate the RMAA or the benefits offered under the RMAA at any time with or without notice).

How the RMAA works

Allocated amount

Each year, Wells Fargo will allocate your retirement medical allowance to an individual bookkeeping account established on your behalf called an “RMAA.” Such funds remain part of Wells Fargo's general assets or remain part of the applicable Trust (if such funding is provided by the applicable Trust). Whether funded from general assets or the applicable Trust, you do not have a separate funded RMAA subaccount; rather a notional bookkeeping account is maintained in your name.

Account activity and status

Log on, at any time, to your online account to access, review, and print your real-time account information. 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

If you have entered your preferred email address on the HealthEquity website, you will receive activity-based email alerts, such as claims payment notices. To check your balance, sign on to your account or call HealthEquity at 1-877-924-3967.

If you do not enter an email address on the HealthEquity website, you will receive information by mail.

Eligible (or qualified) RMAA expenses

To be eligible for reimbursement from your RMAA, the health care expenses must be:

- Considered a deductible medical expense for federal income tax purposes. See IRS Publication 502, “Medical and Dental Expenses,” which is available at <https://www.irs.gov>. Premiums for medical coverage are not eligible for reimbursement from your RMAA. The CARES Act extended the list of RMAA qualified expenses to include menstrual care products and eliminated the requirement for prescriptions for most over-the-counter (OTC) drugs. HealthEquity provides a list of possible eligible medical expenses at <https://participant.wageworks.com>. If you don’t have internet access, you can call HealthEquity for a list of eligible expenses.
- For your or your eligible dependents’ benefit.
- Incurred during the plan year.
- Incurred while you are participating in the RMAA.
- Not reimbursed under any health, dental, or vision plan under which you or your eligible dependents are covered.

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.

Using your RMAA dollars

Option	Best used when	Additional details can be found
Pay My Provider	You want to request that the outstanding balance of a bill for an eligible expense be paid directly to a provider from available funds in the RMAA.	“Pay My Provider (PMP) payment option” section starting on page 4-11
Pay Me Back	You paid the provider with your personal funds and want to be reimbursed for the eligible expense from available funds in the RMAA.	“Filing a claim” section on page 4-11

Ineligible expenses

The RMAA does not allow reimbursements for certain specific expenses, including but not limited to expenses for the following items:

- Charges for the following, even if recommended by your doctor or for general health:
 - Exercise, athletic, or health club membership (except as noted under Eligible Expenses on <https://participant.wageworks.com>)
 - Charges for any illegal treatment
 - Cosmetic treatment or surgery, unless it improves a deformity due to a birth defect, disease, or trauma
 - Drugs or over-the-counter products that are considered cosmetic or used solely for cosmetic purposes (for example, over-the-counter products or prescriptions used to treat hair loss, thinning hair, unwanted hair growth, or hair removal, or teeth whitening procedures or products)
 - Household help
 - Massages
 - Nursing care for a healthy baby
 - Weight loss programs (except as specifically described under Eligible Expenses on <https://participant.wageworks.com>)
- Claims filed after the claims filing deadline
- Concierge fees and expenses for health care services, unless itemization is provided for each date of service
- Day care
- Expenses incurred after the Retiree Plan or your participation in the RMAA ends
- Expenses incurred before your effective date of participation in the RMAA
- Expenses incurred by anyone other than an eligible dependent
- Expenses not allowed as a deduction or credit for federal income tax purposes
- Expenses paid for with health reimbursement account or health savings account 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

HealthEquity provides a list of eligible expenses, including some over-the-counter items, at <https://participant.wageworks.com>. If you don’t have internet access, you can call HealthEquity for a list of eligible expenses.

Claims and appeals

HealthEquity is the claims administrator. The claims administrator is the claims and appeals fiduciary and has the sole and discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the RMAA.

Procedures for filing claims under the RMAA are set forth below. Additional claims and appeals information for the RMAA is included in “[Appendix A: Claims and Appeals](#).”

Filing a claim

To be reimbursed for an eligible RMAA expense, submit a completed and signed Pay Me Back claim form to the claims administrator, HealthEquity. This form is available at <https://participant.wageworks.com>.

Fax to HealthEquity at 1-877-353-9236 or scan and upload to submit the completed and signed forms along with all required supporting expense documentation to HealthEquity. (If you file your claim by fax, keep a copy of the fax confirmation.) You may also mail a copy of the completed forms and required documentation to:

Claims Administrator — HealthEquity
PO Box 14053
Lexington, KY 40512

Keep the original supporting documentation and receipts when mailing a claim. See the “[Required documentation](#)” section on this page for more information.

You can also use the HealthEquity mobile app. It’s a quick and easy way to submit claims and receipts.

Claims filing time frame

Claims for expenses incurred during a plan year must be filed (postmarked, faxed, or electronically submitted as noted above) by April 30 of the following year. You may file a claim as soon as you have incurred an eligible expense, or you may accumulate your expenses and file them together. Claims may only be submitted for expenses incurred for the time you were an RMAA participant.

Example

If you start participating at the beginning of the plan year and then terminate participation on May 15, you may file claims for expenses incurred between January 1 and May 15. You have until April 30 of the next plan year to file these claims.

If, following the April 30 deadline, you have a remaining balance in your RMAA after all eligible expenses for the previous plan year have been reimbursed, your remaining balance will be forfeited and you will lose the opportunity to request additional reimbursements from this balance. Forfeited balances may be applied toward payment of the RMAA’s administrative expenses, to provide benefits under the Retiree Plan, or for any purpose permitted by applicable law. You cannot receive a refund for the unused balance.

Required documentation

You must submit the following documentation with your requests for reimbursement:

- For over-the-counter health care expenses: 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. See the eligible expense list on HealthEquity’s website.
- For medical, dental, or vision copay or coinsurance expenses related to health care services, submit one of the following, as well as a letter of medical necessity when noted as a requirement on the eligible expense list on HealthEquity’s website:
 - An Explanation of Benefits from your medical, dental, or vision plan after your claim has been processed, indicating the patient name, date of service, type of service, service provider, amount charged, amount paid by the applicable plan, and the amount you owe.
 - A copay receipt indicating the patient name, date of service, provider, and copay amount paid. The receipt must state that it is a copay receipt.
- If you do not have medical, dental, or vision coverage, you must provide evidence of your health care expense that includes an itemized billing statement from the provider indicating the patient name, date of service, type of service, service provider, and the amount charged for the service. In some situations, you may also be required to provide a letter of medical necessity; in such situations this requirement will be noted on the eligible expense list on HealthEquity’s website. 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 submitted documentation. If you fax your documentation, keep a copy of the fax confirmation.

Pay My Provider (PMP) payment option

Pay My Provider (PMP) gives you the ability to have HealthEquity make a payment directly from your account to your provider for eligible expenses for RMAA 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 RMAA. An itemized invoice or other appropriate proof of service is required before PMP payments can be issued. The invoice or other documentation must include the dates of service, type of service, service provider, patient’s name, and cost of service. The payment request will remain in the system until the documentation is submitted, but recurring requests that continue through the subsequent plan year, under the same plan, will not have payments to providers issued until the new plan year begins on January 1. One-time requests will be processed and distributed just a few days after the submitted invoice or documentation has been approved (payment requests may not be entered before the service start date). Recurring

payments will be mailed on the requested payment date. You are permitted to enter a requested payment date that is up to 10 calendar days before the due date shown on the contract, if required. A one-time payment cannot be canceled once it is submitted. A recurring payment, however, may be canceled up to 10 days before the requested payment date.

To request a PMP payment, sign on to <https://participant.wageworks.com> and follow the necessary prompts to submit (mail, fax, or scan and upload) your itemized invoice or other appropriate documentation to complete your Pay My Provider request.

Claim payment

Your eligible claims will be paid up to your current account balance. The total annual allocated amount for the plan year is available for you to use as of the first day of the plan year, provided that you are a participant in the RMAA at that time. Your current account balance at any point during the plan year is the total allocated amount, less any claims paid.

Claims will not be paid until they total at least \$25 (except for the final claim payment for the plan year).

You will be reimbursed for claims by check unless you sign up for direct deposit. You may sign up for direct deposit at any time at <https://participant.wageworks.com>.

After your claim for reimbursement has been processed, you will receive your reimbursement with an explanation of your benefit. If you enter your preferred email address at <https://participant.wageworks.com>, you will receive an Explanation of Benefits by email. Otherwise, you will receive one in the mail.

Account claim questions, denied reimbursement, and appeals

If you have a question or concern about a claim processed by the claims administrator, HealthEquity, you may call HealthEquity (see the “[Contacts](#)” section on page 4-2).

For RMAA claims, if your claim was denied (in whole or in part) you may also file a formal written appeal with HealthEquity under the terms of the Retiree Plan. Please note that if you call HealthEquity, your call will not be considered a formal appeal under the terms of the Retiree Plan. A formal written appeal must be filed with HealthEquity within 180 days of the date your claim is denied regardless of any verbal discussions that have occurred regarding your claim. More detailed information on RMAA appeals is provided in “[Appendix A: Claims and Appeals](#).”

Errors and mistakes

The claims administrator or plan administrator has the right to correct errors and make equitable adjustments for any mistakes made in the administration of the RMAA and reserves the right to recover amounts that have been improperly paid. This recovery may be accomplished by any combination of the following:

- Requiring that any overpayment be returned when requested
- Reducing or offsetting a future benefit payment under the Retiree Plan by the amount of any overpayment
- Any other method that the claims administrator or plan administrator determines to be appropriate

The claims administrator or plan administrator also reserves the right to perform audits or reviews to determine that benefits have been properly paid. The plan administrator may require your cooperation in such audits or reviews as a condition for continued participation in the Retiree Plan provided such action is permitted by ERISA or other applicable law.

Chapter 5: Retiree Dental Plan

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Contacts

Information about benefits, ID cards, claims, providers, or covered services	Delta Dental of Minnesota (Delta Dental) https://www.deltadentalmn.org/wf Minneapolis and St. Paul Metro Area: 651-994-5342 All other areas: 1-877-598-5342
Information about enrollment	The Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1 https://benefitconnect.wf.ehr.com/ess
Information about premiums	Check your enrollment materials, or go to https://benefitconnect.wf.ehr.com/ess

The information in this chapter — along with applicable sections of [“Chapter 1: Eligibility, Enrollment, and More,”](#) [“Appendix A: Claims and Appeals,”](#) [“Appendix B: Important Notifications and Disclosures,”](#) [“Appendix D: Retiree Group Tables,”](#) and [“Appendix E: Continuing Coverage Under COBRA”](#) — constitutes the Summary Plan Description (SPD) for the dental benefit option available under the Wells Fargo & Company Retiree Plan (the Retiree Plan). The dental benefit option is also referred to as the retiree dental plan.

The basics

General information

The retiree dental plan is part of the Retiree Plan. The Retiree Plan is a retiree 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 retiree dental plan on the date of service to receive applicable benefits.

The retiree dental plan is administered by Delta Dental and is available in all U.S. locations.

The retiree dental plan covers preventive, diagnostic, basic, and major services, as well as orthodontia, for you and your covered dependents.

If you are enrolled in the retiree dental plan, 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 Retiree 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

For eligibility requirements for retiree dental coverage, refer to the following sections in “Chapter 1: Eligibility, Enrollment, and More”:

- [“Who's eligible — retirees”](#)
- [“Who's eligible — dependents”](#)

You may not be covered under the retiree dental plan as both a retiree and spouse or domestic partner of a retiree, or a retiree and a dependent child of a retiree at the same time. Additionally, a dependent may not be covered under the retiree dental plan as a dependent of more than one retiree. And lastly, you may not be covered under the retiree dental plan if you are covered under the dental plan option of the Wells Fargo & Company Health Plan for active employees and their eligible dependents.

How to enroll and when coverage begins

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

Changing or canceling coverage

You may make limited 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 benefit elections”](#) section in “Chapter 1: Eligibility, Enrollment, and More.”

When coverage ends

Generally, dental coverage ends at age 65. Dental coverage for you or any enrolled dependents also ends as described in the [“When coverage ends”](#) section in “Chapter 1: Eligibility, Enrollment, and More.”

Cost

You must make contributions to pay for the cost of retiree dental coverage. For more information, refer to the [“Cost and funding”](#) section and the [“Payment of retiree coverage”](#) section in “Chapter 1: Eligibility, Enrollment, and More.”

Claims administrator

The retiree 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 retiree 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 retiree dental plan.

How the retiree dental plan works

Although you may use any provider you want, you'll pay less, in most cases, when you use a Delta Dental participating provider because network providers agree to accept Delta Dental's contracted network fee (“allowable fee”) as the maximum charge for covered services. The two networks of participating providers are the Delta Dental PPOSM network and the Delta Dental Premier[®] network. To find out if your provider participates in either of these networks, call Delta Dental at 1-877-598-5342 or visit <https://www.deltadentalmn.org/wf>.

Nearly two-thirds of all dental providers nationwide participate in either the Delta Dental PPO or Delta Dental Premier networks. However, providers in the Delta Dental PPO network have generally agreed to lower contracted fees than providers in the Delta Dental Premier network. If you have access to providers in both networks, you may pay less out of pocket if you receive services from a Delta PPO provider than you would if you receive them from a Delta Dental Premier network provider.

If you use a Delta Dental PPO network provider or a Delta Dental Premier network provider, you will need to identify yourself as a Delta Dental participant when scheduling an appointment. You will not need to file a claim for reimbursement because the network provider bills Delta Dental. You will be responsible for your portion of the contracted allowable fee. You will also be responsible for the full cost of any services not covered by the retiree 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 5-6 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 5-9.

You and all of your covered dependents will receive an ID card from Delta Dental. The ID card includes a subscriber number as your primary identification. The subscriber number is a random (system-generated) member ID that you will need to present when you receive services from a Delta Dental network provider. You must submit out-of-network claims with Delta Dental and must always include your member ID. If you have questions or need additional ID cards, please call Delta Dental's customer service at 1-877-598-5342.

It is important for you to know that when an optional form of treatment is available, the retiree dental plan 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 retiree dental plan. The retiree 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 retiree 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 retiree dental plan.

It is between you and your provider to determine the treatment or procedures that you will receive. The provisions of the retiree dental plan control what, if any, benefits are available for the services you receive.

Pretreatment estimate

A pretreatment estimate can help you make informed decisions about treatment. You should get a pretreatment estimate if your treatment is estimated to cost \$300 or more. The pretreatment estimate is also recommended for orthodontia services. Your provider can use a Delta Dental claim form or a standard American Dental Association (ADA) form and check the pretreatment box. The provider should include the following:

- Preliminary findings
- Recommended corrective procedures
- Estimated charges
- Length of treatment for orthodontia claims

The pretreatment estimate should be sent to:

Delta Dental of Minnesota
PO Box 9120
Farmington Hills, MI 48333-9120

When the review is complete, Delta Dental will send a pretreatment estimate statement to you and your provider. This estimate will include an explanation of:

- Your estimated out-of-pocket expenses
- An estimate of the services the retiree dental plan 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 expected portion of the cost and coverage that may be provided under the retiree dental plan. 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 retiree dental plan 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 the retiree dental plan 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 does not receive a pretreatment estimate from Delta Dental within 30 days of the request, contact Delta Dental at 1-877-598-5342.

If you elect not to use the pretreatment estimate service, Delta Dental will not review your claim until you file it. If it is determined that the service is not covered under the retiree dental plan or is not the most cost-effective method of treatment (as determined by Delta Dental), no benefits will be paid unless otherwise indicated in this chapter.

What the retiree dental plan covers

Your retiree 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 retiree 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 5-6 for more information on the allowable fees.

Benefit features	Retiree dental plan
Annual deductible	\$50 per person. Diagnostic, preventive care, and orthodontia are not subject to the deductible. For all other services, you first pay the deductible before the retiree dental plan pays for covered services.
Annual maximum benefit	\$1,500 per person. Diagnostic, preventive care, and orthodontia are not applied to the annual maximum.
Diagnostic and preventive care	Covered at 100%. ¹
Basic care <ul style="list-style-type: none">• Fillings and oral surgery• Periodontics• Endodontics	You pay 20% after your deductible. You pay 20% after your deductible for most care. For composite (white) fillings on posterior teeth, you pay 30% after your deductible. You pay 20% after your deductible. You pay 20% after your deductible.
Major restorative services <ul style="list-style-type: none">• Dental implants• Prosthetics and repairs	You pay 50% after your deductible. You pay 50% after your deductible. You pay 50% after your deductible.
Orthodontia²	You pay 50%. There is a \$1,500 lifetime maximum benefit per person.

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 5-6.

2. Orthodontia benefits paid under the former Wachovia Dental Program, a component of the former Wachovia Corporation Health and Welfare Plan, will be applied when determining the lifetime maximum orthodontia benefit under the Retiree Delta Dental coverage options. See the [“Orthodontia benefits”](#) section on page 5-7 for more information.

Frequency limits

Certain diagnostic and preventive care, basic care, and major care services covered by the Delta Dental coverage options are subject to frequency limitations, even if they are dentally necessary to treat your specific dental condition. These limits apply to services previously received, regardless of coverage or benefits issued for the service.

For the purposes of this chapter describing dental benefits and applicable frequency limits, the plan year is the same as a calendar year, beginning on January 1 and ending the following December 31.

You are responsible for paying for the full cost of dental services that are not covered by the retiree dental plan.

Allowable fees and benefit payments

Providers who participate in the Delta Dental PPO network or Delta Dental Premier network have signed a participating and membership agreement with Delta Dental. These network providers have agreed to accept Delta Dental's contracted fee as the maximum charge for covered services; this is the allowable fee for covered services received from a network provider. Participating network providers will file the claim for you and payment will be made directly to the network provider. You will be responsible for any applicable deductible and coinsurance amounts for covered services, as described in the ["Your retiree dental benefits and costs at a glance"](#) table on page 5-5. You are also responsible for the full cost of any services not covered by the retiree dental plan.

If you use an out-of-network provider, claim payments are based on the lesser of the treating provider's submitted charge or the table of allowances established by Delta Dental. The table of allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed out-of-network provider. When services are received from an out-of-network provider, you must file the claim, and claim payments are sent directly to you. You are responsible for any applicable deductible and coinsurance amounts for covered services, as described in the ["Your retiree dental benefits and costs at a glance"](#) table on page 5-5. You are also responsible for all charges not covered by the retiree dental plan. It is your obligation to pay the out-of-network provider for all services received.

Diagnostic and preventive care

The retiree dental plan covers 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
- Comprehensive periodontal evaluation, once per plan year
- Consultation, one in a six-month period
- 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 procedures, up to four per plan year
- Sealants or preventive resin restorations for children under age 16 for six- and 12-year permanent molars, once per tooth per lifetime, both procedures combined
- Single-film x-rays as required for specific diagnoses
- Space maintainers for children under age 19 to replace extracted posterior primary teeth only
- Teeth cleaning, twice per plan year
- Topical fluoride applications for children under age 18, once per plan year

Basic care

The retiree dental plan covers 80% 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.
- Composite (white) fillings for back teeth. The retiree dental plan covers 70% of the cost for composite or resin fillings for back teeth. Limited to once every two years per surface.
- 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.
- 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.
- 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.
- White fillings for front teeth, limited to once every two years per surface.

Major care

The retiree dental plan covers 50% 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.
- Removable, fixed, or cemented habit-breaking appliances (including adjustment and treatment of appliances), limited to one appliance per covered member.
- 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 retiree dental plan.

- Single-tooth implant body, abutment, and crown, once every five years for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment, and implant abutment supported crown. Some adjunctive implant services may not be covered. Therefore, it is recommended that a pretreatment estimate be requested to estimate the amount of payment before beginning treatment.
- Veneers used to restore lost tooth structure as a result of tooth decay or fracture on anterior permanent teeth, once every five years per tooth. After a tooth has been restored using a veneer, no other major restoration will be covered on that tooth for five years.

Orthodontia benefits

The retiree dental plan covers 50% of the allowable fees for eligible orthodontia expenses. Orthodontics must be performed and supervised by a licensed dentist or orthodontist who has established the need for such procedures through a complete in-person oral examination, and has developed a proper treatment plan through adequate diagnostic activities, including radiographic imaging (x-rays).

The total lifetime orthodontia benefits paid per person cannot exceed \$1,500. In applying the total lifetime orthodontia benefits, the retiree dental plan will reduce the available \$1,500 lifetime benefit by the amount of any orthodontia benefits previously received by a covered person under the retiree dental plan, the Wells Fargo dental coverage options administered by Delta Dental under the Wells Fargo & Company Health Plan, and the former Wachovia Dental Program, a component of the former Wachovia Corporation Health & Welfare Plan.

The retiree dental plan covers the following types of orthodontia expenses:

- Preliminary studies for orthodontic program, 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 in the “[Pretreatment estimate](#)” section on page 5-4, so both you and your orthodontist may receive an estimate of what the retiree dental plan is expected to cover. For more information, see the “[Orthodontia claims](#)” section on page 5-9.

What is not covered

Charges for some types of dental work will not be covered by the retiree dental plan. These charges include:

- Accidental injury to natural teeth covered by any medical plan or medical benefit program
- Anatomical crown exposure
- Anesthesiologist services
- Antimicrobial and biologic material
- Appliances, restorations, and procedures to alter vertical dimension (increasing height of upper and lower teeth)
- Athletic mouth guards
- Bacteriologic tests
- Brush biopsy and the accession of a brush biopsy
- Case presentations
- Charges for completing claim forms or for missed appointments
- Charges for services provided other than the least costly appropriate restorative procedure as determined by Delta Dental
- Charges incurred after your dental coverage under the Retiree Plan ends
- Claims filed later than 12 months from the date of service when you choose an out-of-network provider
- Comfort or convenience items
- Cone beam images
- Crown lengthening, except as noted in the “[Basic care](#)” section on page 5-6
- Cytology sample collection
- Educational programs, such as dietary instruction or training for plaque control or oral hygiene
- Enamel microabrasion and odontoplasty
- Extra sets of dentures or other appliances if benefits were previously provided
- Facility charges
- Finance or late charges
- Genetic testing
- Guided tissue regeneration
- Incomplete or interim procedures
- Injury or disease covered by Workers’ Compensation or other similar laws; this exclusion applies to any covered person, including the retiree, a spouse or domestic partner, or a dependent child
- Injury or disease incurred in connection with and while in self-employment or in the employment of someone else for wages or profit, including farming
- Office visit in which no dental procedures are performed and that is not a dental consultation
- Orthodontics not performed and supervised by a licensed dentist or orthodontist who has established the need for such procedures through a complete in-person oral examination, and has developed a proper treatment plan through adequate diagnostic activities, including radiographic imaging (x-rays)
- Pediatric partial denture, fixed
- Periodontal splinting (temporary wiring or permanently bonding teeth together)
- Prescribed medications
- Preventive resin restoration
- Provisional pontic and provisional retainer crown
- Provisional splinting (intracoronal or extracoronal)
- Pulpal regeneration
- Repair or replacement of any orthodontic appliance
- Replacement of existing dentures or bridgework unless listed in the “[Major care](#)” section on page 5-7
- 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 retiree dental plan or the Wells Fargo dental coverage options administered by Delta Dental under the Wells Fargo & Company Health Plan
- Services completed before the date the covered person became eligible for the coverage
- Services not indicated as covered
- Services or supplies not recommended or prescribed by a dentist, orthodontist, or oral surgeon
- Special stains applied to biopsies or surgical specimens
- Temporary anchorage devices
- Temporary procedures
- Temporomandibular joint dysfunction (TMJ)-related procedures, appliances, restorations, and diagnostic services, whether medical or dental in nature
- The portion of the cost for a service that is above the allowable fee for that service
- Therapeutic drug injections
- Treatments and appliances in connection with congenitally missing teeth
- Treatment covered by another group plan through an employer, HMO, mutual benefit association, labor union, trustee, or another similar group plan
- Treatment in excess of yearly or lifetime maximum benefit or frequency limits

- Treatment needed as a result of any intentional, self-inflicted injury
- Treatment not approved by the Council of Dental Therapeutics of the American Dental Association or treatment that is experimental in nature
- Treatment provided for cosmetic reasons
- Treatment provided while not covered under the retiree dental plan
- 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 retiree dental plan are set forth in “[Appendix A: Claims and Appeals](#).” Additional information regarding the filing of claims and appeals unique to the retiree dental plan is described below.

Delta Dental is the claims administrator and the named claims and appeals fiduciary for the retiree 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 retiree dental plan.

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 Retiree Plan at the time of your appointment. The network provider’s office will file the claims, which must be filed with Delta Dental within 12 months of the service date.

If the claim is approved, benefit payment will be issued directly to the network provider indicating that the claim has been paid. If the claim is not approved (in whole or in part) or needs additional information, you will receive an Explanation of Benefits indicating the reason for nonpayment.

You are responsible for payment of deductibles, coinsurance, and any other payments to the network provider for services not covered by the retiree dental plan. 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 timely filed.

You can use a Delta Dental claim form or a standard ADA claim form available at the provider’s office. You may get a claim form from Delta Dental at <https://www.deltadentalmn.org/wf> or you may call Delta Dental at 1-877-598-5342. Send the completed claim form to Delta Dental of Minnesota within 12 months of the date of service at the following address:

Delta Dental of Minnesota
PO Box 9120
Farmington Hills, MI 48333-9120

Providing all needed information when filing a claim can help avoid delays in processing the claim. If the claim is approved, a check is produced along with an Explanation of Benefits, and both will be issued to you. Delta Dental does not issue payments to out-of-network providers. If the claim is not approved (in whole or in part) or needs additional information, you will receive an Explanation of Benefits indicating the reason for nonpayment.

You are responsible for paying the out-of-network provider in full.

Orthodontia claims

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of the treatment.

Treatment beginning after coverage is effective

Before services are received, the provider should submit a pretreatment estimate of total cost to Delta Dental. For more information, see the “[Pretreatment estimate](#)” section on page 5-4.

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 of submitting the pretreatment estimate, 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 retiree dental plan 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 retiree dental plan, 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 the retiree dental plan, 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 your coverage at the time of appliance banding and the number of months of active treatment remaining.

Orthodontia benefits paid under the former Wachovia Dental Program, a component of the former Wachovia Corporation Health & Welfare Plan, and the Wells Fargo & Company Health Plan dental coverage options will be applied to the lifetime maximum benefit under the Wells Fargo retiree dental plan.

Coordination of benefits

The retiree dental plan includes 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 this retiree dental plan is the secondary payer, then this retiree dental plan 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 this retiree dental plan would have paid \$400 as the primary plan, and your primary plan pays \$400 or more, then this retiree dental plan will pay nothing.

Delta Dental's calculation of what it would pay if this retiree dental plan 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, this retiree dental plan would pay nothing for that claim.

Also, there is no coordination of benefits between benefit options under the Retiree Plan. Benefits will not be paid from more than one Retiree Plan benefit option for the same services. For example, you cannot receive benefits under the Retiree 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 retirees and their spouses or domestic partners, the plan covering the patient as a retiree or 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:
 - 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.

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 Retiree Plan. Please note that if you call Delta Dental, your call will not be considered a formal appeal under the terms of the Retiree 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 5-2. 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 Retiree Plan (the Retiree Plan). The Retiree Plan has the right to recover benefits it has paid on your or your dependent's behalf that were: (a) made in error, (b) due to a mistake in fact, (c) paid before you meet the annual deductible, (d) caused by the act or omission of another party, (e) covered by no-fault or employers' liability laws, (f) available or required to be furnished by or through national or state governments or their agencies, or (g) the result of injury sustained on the property of a third party. Benefits paid because you, your dependent, or provider misrepresented facts are also subject to recovery. Right of recovery may be pursued by claims reprocessing, by notification of overpayment, or through the

subrogation process. In addition, the rights of reimbursement and subrogation apply whether or not you or your dependent have been fully compensated for losses or damages by any recovery of payments, and the Retiree 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 Retiree 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 Retiree Plan's benefit to the extent of subrogation or reimbursement claims. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made from such constructive trust until the Retiree Plan's subrogation and reimbursement interests are fully satisfied. You agree to cooperate fully in every effort by the Retiree Plan to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to inform the Retiree Plan in writing within 30 days of giving notice to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents also agree to provide written notice to the Retiree Plan prior to receipt of any recovery or within 5 days if no notice was given prior to your receipt of the funds.

Recovery of overpayments

If the Retiree Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree Plan. The claims administrator or the plan administrator, on behalf of the Retiree Plan, may send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Retiree 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 Retiree Plan
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Retiree Plan

Reimbursement policy

The right of reimbursement means you must repay the Retiree 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 Retiree Plan will not cover the value of the services to treat such an injury or condition, or the treatment of such an injury or condition. However, the Retiree Plan may advance payment to you for these dental expenses if you, or any person claiming through or on your behalf, agree to do both of the following:

- Grant to the Retiree Plan a first priority lien against any proceeds of any settlement, verdict, or insurance proceeds received by you or on your behalf as a result of the third party's actions and are to be repaid to the Retiree Plan before you receive any recovery for your damages
- Assign to the Retiree Plan any benefits you may receive under any automobile policy or other insurance coverage, to the full extent of the Retiree Plan's claim for reimbursement

You must sign and deliver to the claims administrator or the plan administrator on behalf of the Retiree Plan, as directed, any documents needed to protect the Retiree 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 Retiree 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 Retiree 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 Retiree Plan after receipt of a settlement, verdict, judgment, award, or insurance proceeds, the Retiree Plan may not pay for any future expenses, whether anticipated or unanticipated, relating to your injury or condition. In addition, the Retiree Plan may seek legal action against you to recover paid dental benefits related to your injury or condition. In addition, the Retiree 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 Retiree Plan.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Subrogation

Under the reimbursement method of subrogation, you reimburse the Retiree Plan any money you receive through a settlement, verdict, judgment, award, or insurance proceeds. At its sole discretion, the Retiree Plan also has the option of directly asserting its rights against the third party through subrogation. This means that the Retiree Plan is subrogated to all of your rights against any third party who is liable for your injury or condition. The Retiree 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 Retiree Plan. The Retiree Plan may make a claim in your name or the Retiree Plan's name against any persons, organizations, or insurers on account of such injury or condition. The Retiree Plan may assert this right independently of you.

You are obligated to cooperate with the Retiree Plan and its agents in order to protect the Retiree Plan's subrogation rights. Cooperation means providing the Retiree Plan or its agents with any relevant information as requested, signing and delivering such documents as the Retiree Plan or its agents request to secure the Retiree Plan's subrogation claim, and obtaining the Retiree 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 Retiree Plan. Any costs incurred by the Retiree Plan in matters related to subrogation may be paid for by the Retiree Plan. The costs of legal representation you incur will be your responsibility.

Attorneys' fees and expenses that you incur in connection with the recovery of money from third parties may not be deducted from subrogation or reimbursement amounts, unless agreed to by the plan administrator in its discretion, or by the plan administrator's designee. Accordingly, the "Common Fund" doctrine will not apply to any recovery of money by you or on your behalf.

Interpretation

In the event that any claim is made that any part of this "Right of recovery" section is ambiguous, or questions arise concerning the meaning of the intent of any of its terms, the plan administrator or its designees shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this "Right of recovery" section. The Retiree Plan's rights reflected in this "Right of recovery" section for retiree dental benefits are in addition to and not in lieu of any similar rights that may be associated with other benefit options under the Retiree 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 Retiree 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 Retiree Plan or its designee may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond to you by reason of your present or future domicile.

Chapter 6: Retiree Life Insurance Plan

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Contacts

Information about retiree life insurance benefits	Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1
To file a claim	Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1
Claims status	Metropolitan Life Insurance Company (“MetLife”) 1-866-549-2320

The information in this chapter — along with the applicable sections of “[Chapter 1: Eligibility, Enrollment, and More](#)” (only portions of “The basics”, “Benefit plan options” and “Rehired retirees” subsection of “When coverage ends”) and certain information in “[Appendix B: Important Notifications and Disclosures](#)” (only the information in the “Your rights under ERISA,” “Plan Information,” and “Future of the Plans” sections and the Retiree Life Insurance Plan information in the “ERISA plans sponsored by Wells Fargo” section) — constitutes the Summary Plan Description (SPD) for the Wells Fargo & Company Retiree Life Insurance Plan.

The basics

General information

The retiree life insurance benefits described in this chapter are only available to certain retired employees.

The retiree life insurance benefits described in this chapter are provided through the Wells Fargo & Company Retiree Life Insurance Plan (the Retiree Life Insurance Plan).

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 Retiree Life Insurance Plan. The retiree life insurance policy is a term life policy and has no cash value.

If you would like a copy of the Retiree Wells Fargo Group Term Life Certificate of Insurance for the Retiree Life Insurance Plan, contact the Wells Fargo Retirement Service Center. The Retiree 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 Retiree Life Insurance Plan is insured by Metropolitan Life Insurance Company (“MetLife”). MetLife has the discretionary authority to administer claims and interpret benefits under the Retiree Life Insurance Plan.

Future of retiree life insurance benefits

Wells Fargo & Company reserves the right to amend, modify, or cancel retiree life insurance coverage at any time and for any reason. Please see the “[Future of the plans](#)” section in “[Appendix B: Important Notifications and Disclosures](#)” for more information.

Retiree life insurance

Who’s eligible

Certain retirees from Wells Fargo & Company and its affiliates and certain retirees from entities that merged with or were acquired by Wells Fargo & Company (or one of its affiliates) who were eligible for company-paid retiree life insurance coverage under the Retiree Life Insurance Plan are eligible.

Coverage amount

Coverage amounts shall be in accordance with the amount in force at the time of retirement (as reduced by any applicable age reduction table or plan provision) and shall not exceed the amount maintained by the recordkeeper on its system for which premiums are paid to the insurer. The current amount of retiree life insurance coverage available can be obtained by contacting the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

Rehires

If you are a former eligible retiree, and you are rehired by Wells Fargo & Company (or an affiliate of Wells Fargo & Company) as a regular or part-time employee, your retiree life insurance coverage will continue under the Retiree Life Insurance Plan.

Cost

Wells Fargo pays the entire cost for the retiree life insurance coverage.

Imputed income

The information in this section is not intended to provide tax advice. Federal and state tax laws may differ. Consult a tax advisor for information about your specific situation.

Wells Fargo & Company pays life insurance premiums on your behalf for retiree life insurance. Under federal tax code, the cost of the company-paid coverage for life insurance values over \$50,000 will be considered “imputed income,” or taxable income to you, which is also subject to applicable Social Security and Medicare taxes. As a result, retirees will receive a W-2 form to account for the applicable amount of imputed income.

Canceling coverage

You may cancel your coverage at any time by calling the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1 and speaking with a customer service representative. The coverage will be changed effective the first of the month following your call to the Service Center. Coverage cannot be canceled retroactively. Once you cancel your retiree life insurance coverage, it cannot be reinstated.

When coverage ends

Retiree life insurance coverage ends on the date the plan is no longer offered* or on the last day of the month in which one of the following occurs:

- You no longer meet the benefits eligibility requirements (for eligibility requirements, see the “Who’s eligible” section on this page).
- You voluntarily cancel coverage.
- Retiree life insurance coverage also ends when you die.

* For information on Wells Fargo’s ability to amend, modify, or terminate the Retiree Life Insurance Plan, see the “[Future of the plans](#)” section in “Appendix B: Important Notifications and Disclosures.”

Beneficiaries

When you die, benefits will be paid to the person, persons, trust, or institution you designated as beneficiary. A beneficiary may be a person, trust, charitable institution, or your estate. If a minor child is named as the beneficiary, the proceeds will go into a locked interest-bearing account, known as a Minor on Deposit Account, until the child turns 18, when MetLife will contact the beneficiary and provide information on accessing the funds. If a guardian of the child’s estate or conservator of the child’s estate has been appointed by the court, the benefits can be paid to the child’s estate. You can designate or change a beneficiary at any time by calling the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1 or by signing on to benefitconnect.wf.ehr.com/ess and accessing the “**My Beneficiaries**” section under “**My Profile**.”

Important note: The beneficiary designations of retirees in place on December 31, 2009, will remain in place unless and until the retiree contacts the Wells Fargo Retirement Service Center to designate a different beneficiary.

Multiple beneficiaries

If you have two or more designated beneficiaries, 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 life insurance 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 if the primary beneficiary dies before you or at the same time as you.

If you and your primary beneficiary die within a 24 hour period, the death benefit will be paid to the beneficiary receiving payment of your life insurance or to your estate.

Payout if no surviving or designated beneficiaries

If a beneficiary is not designated or the beneficiary dies before you, the death benefit may be paid to the following individuals in the order listed below:

1. Your surviving spouse or domestic partner¹
2. Equally among your surviving biological or adopted children²
3. Equally between your surviving parents
4. Equally among your surviving brothers and sisters
5. Your estate

If you are not the biological or adoptive parent of your spouse’s or domestic partner’s child but would like that child to receive benefits in the event of your death, you must properly designate the child as your beneficiary.

1. See the “Definitions relating to marital status” section on this page for more information.

2. Except that if any of the participant’s children predecease him or her but leave descendants surviving, such descendants shall take by right of representation the share their parent would have taken, if living.

Definitions relating to marital status

For payment of a benefit if there are no surviving or designated beneficiaries, the following terms have the meanings assigned to them below:

- “Spouse” means the person to whom you are legally married on your date of death under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, or the person who was your current common-law spouse on your date of death in a legally recognized common-law marriage, contracted in a state that recognizes common-law marriages.
- “Domestic partner” means a person of the same or opposite gender who is not your spouse as defined above, that meets at least one of the following criteria on your date of death:
 - You and the person are joined in a civil union (or other similar formal relationship) on your date of death that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the union was created but is not denominated or recognized as a marriage under the laws of that state or country.
 - You and the person share a domestic partnership (or other similar formal relationship) on your date of death that is registered by a city, county, state, or country but is not denominated or recognized as a marriage under the laws of that city, county, state, or country.

- You and the person both meet all of the following requirements:
 - i. You shared a single, intimate, committed relationship of mutual caring as of your date of death and intended to remain in the relationship indefinitely.
 - ii. You resided together in the same residence and lived in a spouse-like relationship as of your date of death.
 - iii. You are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which you reside as of your date of death.
 - iv. Neither of you was married to another person under either federal, state, or common law, and neither is a member of another domestic partnership as of your date of death.
 - v. You were both mentally competent to consent or contract.
 - vi. You were both at least 18 years old.
 - vii. You were financially interdependent, jointly responsible for each other's basic living expenses, and if asked, your partner is able to provide documentation for three of the following being in effect as of your date of death:
 - A. Joint ownership of real property or a common leasehold interest in real property
 - B. Common ownership of an automobile
 - C. Joint bank or credit accounts
 - D. A will that designates the other as primary beneficiary
 - E. A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other
 - F. Designation of one partner as holding power of attorney for health care decisions for the other

Plan Benefits

Accelerated Benefit

Coverage under the Retiree Life Insurance Plan 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 Retirement Services directly at 1-877-HRWELLS (1-877-479-3557), option 1 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 Retiree Life Insurance Plan.
- Be terminally ill (expected to die within 12 months).
- Send proof of terminal illness to MetLife that the insured's life expectancy, because of sickness or injury, is 12 months or less. This must include certification by a physician. MetLife retains the right to have the insured medically examined at MetLife's expense to verify the medical condition.

An Accelerated Benefit is not available if the insured is:

- Required by law to use this as an option to meet the claims of creditors, whether in bankruptcy or otherwise.
- Required by a government agency to use this as an option to apply for, obtain, or keep a government benefit or entitlement.

The Accelerated Benefit option will end on the earliest of:

- The date life insurance coverage terminates.
- The date you transfer ownership of (assign) your life insurance benefits.
- The date you have accelerated all life insurance benefits.

If the insured qualifies for an Accelerated Benefit, he or she can request either a full or partial payment as shown in the table below.

Accelerated Benefits

	Full Accelerated Benefit	Partial Accelerated Benefit
Benefit amount	100% of the life insurance coverage amount in effect at the time of the request, up to a maximum of the amount of retiree life coverage in effect at the time of the request	Any partial amount of the life insurance coverage amount in effect at the time of the request, up to a maximum of the amount of retiree life coverage in effect at the time of the request
Policy in force	Coverage ceases	Coverage remains in force less the amount accelerated

Benefits received under this Accelerated Benefit provision may be taxable. The insured should seek assistance from a tax advisor before requesting an accelerated payment of death benefits. The Accelerated Benefit can only be paid once for each eligible life insurance participant.

Transfer of ownership

You may transfer ownership, also referred to as assigning your rights, under the Retiree Life Insurance Plan to another individual, Trust, or Viatical Settlement Provider. This means that:

- You automatically waive any rights to change your beneficiary.
- You become ineligible for the Accelerated Benefit.

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. Contact the Wells Fargo Retirement Service Center for additional information on how to transfer ownership. 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 Retiree Life Insurance Plan or your coverage amount.

Retiree Life Insurance Plan claims and appeals

Filing a claim

To file a claim under the Retiree Life Insurance Plan, follow these steps:

1. Contact the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1 to begin the claims process as soon as possible after the insured's death. (The Wells Fargo Retirement Service Center will inform MetLife of the insured's death after step 1 has been completed.)
2. Send a copy of the certified death certificate and a Beneficiary Statement to MetLife after receiving a letter directly from MetLife requesting such documentation.

Claim determination

After your beneficiary has followed the steps for filing a claim, MetLife processes the claim. MetLife may require additional documents to make a determination of payment. MetLife will make these requests directly to your beneficiary.

If the claim is approved, the benefit will be paid within 10 days of receipt of all required documentation.

The beneficiary will receive written notice from MetLife to inform them of the decision to approve or deny the claim (regardless of whether the claim is complete with all necessary information). This notification will be provided to the beneficiary 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 your beneficiary 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 Retiree 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 the right to appeal the decision and an explanation of the appeal procedure, including a statement of the right to bring a civil action under Section 502(a) of ERISA following a denial of the claim on appeal

If you have questions about the claim determination, you can call MetLife at 1-866-549-2320. You also have the right to file an appeal without first calling the insurer.

Filing an appeal

When any claim is denied in whole or in part, the 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 your beneficiary requests a review, the beneficiary should include the following:

- The reason your beneficiary believes the claim was improperly denied
- Any written comments, documents, records, or other information deemed appropriate

Authorizing a representative

A beneficiary has the right to have someone file an appeal review request on their behalf or represent them in the appeal process. To authorize someone to represent them, the beneficiary must submit a written authorization to MetLife that includes the following:

- The name and address of the person authorized to represent them
- The purpose for which the individual is representing them
- The time period for which the individual will be the beneficiary's authorized representative
- The types of documents, records, or other items that may be requested of or released to the authorized individual

Note: Neither the insurer, the plan administrator, Wells Fargo, nor the plan are responsible for an authorized representative's disclosure of information provided to the authorized representative or that individual's failure to protect such information.

If you or your beneficiary wish for an authorized representative to request and receive a copy of the SPD or plan document, an authorization for representation statement as described above must be submitted to the plan administrator with the SPD or plan document request.

Appeal review and determination

If the beneficiary requests a review, MetLife's written decision is sent directly to the beneficiary within 60 days after MetLife's receipt of the review request. If an extension is required, MetLife will notify the 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 Retiree Life Insurance Plan provisions on which the denial is based
- Any voluntary appeal procedures offered by the Retiree Life Insurance Plan
- A statement that the beneficiary is entitled to receive — upon request and free of charge — all documents, records, and other information relevant to the claim for the Retiree Life Insurance Plan benefits
- A statement of the right to bring a civil action under Section 502(a) of ERISA

MetLife (the insurer) shall serve as the named fiduciary under the Retiree 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 Retiree Life Insurance Plan, any and all questions arising from:

- Administration of claims and interpretation of all provisions of the Retiree Life Insurance Plan
- Determination of all facts that are relevant to a claim for benefits
- Determination of the documents, records, and other information that are relevant to a claim for benefits
- Determination of benefits to be provided to any participant or beneficiary
- Construction of all terms of the policy

Decisions by MetLife shall be conclusive and binding on all parties.

Neither the plan administrator nor Wells Fargo provides a review of claims for retiree life insurance benefits or pays any retiree life insurance benefits.

Legal action

No legal action can be taken until the Wells Fargo & Company Retiree Life Insurance Plan's claims and appeals procedures have been exhausted (refer to the "[Claims and appeals](#)" section starting on page 6-6 for more information).

Eligibility and enrollment disputes

The plan administrator (as defined in "[Appendix B: Important Notifications and Disclosures](#)") has sole and complete discretionary authority when it comes to determining eligibility for retiree life insurance coverage, subject to the terms of applicable documents or instruments governing the Retiree Life Insurance Plan. Eligibility and enrollment decisions made by the plan administrator, not subject to the claims and appeals procedures, are conclusive and binding on all parties and are not subject to further review.

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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 and dental plan options under the Wells Fargo & Company Retiree Plan (the Retiree Plan).

This appendix describes the claims and appeals procedures for the following:

Wells Fargo & Company Retiree Plan

- UnitedHealthcare administered:
 - HRA-Based Medical Plan
(including Out of Area coverage)
 - HSA-Based Medical Plan*
 - UnitedHealthcare Temporary Medicare Supplement Plan
- Express Scripts administered prescription drug benefit:
 - HRA-Based Medical Plan
(including Out of Area coverage)
 - HSA-Based Medical Plan*
- Delta Dental administered dental benefit
- Retirement Medical Allowance Account administered by HealthEquity

* Your HSA is not part of the Retiree Plan and these claims and appeals procedures do not apply. Refer to “[Appendix C: Health Savings Accounts](#)” for more information about your HSA.

Additional claims procedures specific to each particular benefit option listed above are also found in the individual medical and dental chapters of this *Retiree Benefits Book*, or for the UnitedHealthcare Temporary Medicare Supplement Plan, in the separate applicable Summary Plan Description (SPD) booklet.

If you are enrolled in a fully insured Kaiser medical option under the Retiree Plan, refer to the Evidence of Coverage or similar documentation provided directly from or made available to you by Kaiser (visit <https://my.kp.org/wf> or [kp.org/eoc](https://my.kp.org/eoc)) for applicable claims and appeals procedures.

If you are enrolled in the fully insured UnitedHealthcare Group Medicare Advantage (PPO) medical option under the Retiree Plan, refer to the Evidence of Coverage, Summary Plan Description, or similar documentation provided directly or made available to you by from UnitedHealthcare for applicable claims and appeals procedures.

For information about the claims and appeals procedures for benefits not addressed above, refer to the applicable chapter within this *Retiree 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 plan 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 benefit options under the Retiree Plan 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 the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557).

Claims

A claim is any request for a plan benefit made in accordance with these claims procedures.

A claim is considered to be filed when it is received by the applicable claims administrator in accordance with these claims procedures. The time period for providing notice of a determination starts when the claim is filed, regardless of whether the claims administrator has all of the information necessary to decide the claim at the time the claim is filed.

If a claim does not include sufficient information for the claims administrator to make an initial benefit determination, you may be asked to provide additional information needed to make the determination. Your failure to provide the additional information requested within the applicable time period identified in the “[Initial claims procedures](#)” table on page A-8 may result in the denial of your claim, in whole or in part.

For purposes of this appendix, references to “you” may include your authorized representative or your provider if your provider is submitting a claim on your behalf. To authorize someone to represent you through the claims process, you must submit a written authorization to the applicable claims administrator. The authorization must specify who is representing you, for what purpose, for what duration of time, and what documents, records, or other items may be released to or requested of this representative. For more information, see the “[Authorizing a representative](#)” section on page A-9. In the case of a claim involving urgent care, a health care professional with knowledge of your medical condition shall be permitted to act as your authorized representative.

There are four types of claims, defined under the “[Definitions](#)” section starting on page A-3. Different claims and appeals procedures, as described in this appendix, apply to each type of claim.

Definitions

Adverse benefit determination

An adverse benefit determination means any of the following:

- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of your eligibility to participate in a benefit option under the Retiree Plan
- Failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, unproven, investigational, or not medically necessary or appropriate

Claimant

A claimant is a participant in the applicable benefit option under the Retiree 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 payment of the benefit is conditioned in whole or in part on receiving the advance approval or authorization from the applicable claims administrator before obtaining services. Depending on the claims administrator, a pre-service claim may also be referred to as prior authorization.

If a service requires pre-service authorization to receive benefits but the service is provided before receiving authorization or approval from the applicable claims administrator, the claim will be reviewed as a post-service claim.

Note: Casual inquiries about the benefits or the circumstances under which benefits might be paid under your benefit option are not considered pre-service claims subject to these procedures, nor are requests for approval when preapproval is not required to receive benefits.

Urgent care claim

An urgent care claim is any pre-service claim for medical care or treatment with respect to which the application of the time periods for making pre-service care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a pre-service claim is an urgent care claim will be determined by the attending provider, and the claims administrator and the Retiree 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 Retiree 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 (in-network) provider (for the medical plan options for retirees not yet eligible for Medicare)

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 Retiree 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 Retiree Plan as directed by the claims administrator.

Services from an out-of-network provider or if you are covered under the UnitedHealthcare Temporary Medicare Supplement Plan

If you are using an out-of-network (also known as “nonnetwork”) provider or if you are covered under the UnitedHealthcare Temporary Medicare Supplement Plan, it is your responsibility to make sure that the claim is filed correctly and on time even if the 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 provider in full.

If you provide written authorization to allow direct payment to the provider, benefits may be paid directly to the provider instead of being paid to you if either of the following is true:

- The 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 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 Retiree 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 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 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 Retiree 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.

Note: There are no pre-service, urgent care, or concurrent care claim requirements for medical claims under the UnitedHealthcare Temporary Medicare Supplement Plan, but there may be such requirements related to prescription drug claims.

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 retiree
- Wells Fargo group number and individual member number
- Medical condition (diagnosis) and the treatment or service for which approval is being requested
- Service provider’s name
- Medical records or other documentation to support the request for approval
- Any additional information requested by the claims administrator upon notification

Note: If the services are provided before a determination is made for a claim that started out as a pre-service, urgent care, or concurrent care claim, the claim may be treated as a post-service claim.

Failure to follow claims procedures — pre-service, urgent care, and concurrent care claims

If you do not follow proper claims procedures, the claims administrator will notify you of the failure and the proper procedures to be followed. Such notification may be verbal unless you specifically request written notification.

- For **pre-service** claims, you will be notified within five days from the date the claims administrator received the request.
- For **urgent care** claims, you will be notified as soon as possible but not later than within 24 hours from the time the claims administrator received the request. Notification may be verbal unless you specifically request written notification.
- For **concurrent care** claims, you will be notified as noted above depending on whether the request qualifies as an urgent care claim or a pre-service claim.

Contacts for pre-service, urgent care, and concurrent care claims

Benefit plan option	Contact
<ul style="list-style-type: none"> • HRA-Based Medical Plan • HSA-Based Medical Plan 	<p>UnitedHealthcare 1-800-842-9722</p> <p>For urgent care claims, specifically state that the claim is an urgent care claim.</p> <p>UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130</p> <p>For prescription drug claims, refer to the information in the row titled “Express Scripts administered prescription drug benefit.” below.</p>
<p>UnitedHealthcare Temporary Medicare Supplement Plan (prescription drug coverage only)</p> <p>Note: There are no pre-service, urgent care, or concurrent care claim requirements for medical claims under the UnitedHealthcare Temporary Medicare Supplement Plan.</p>	<p>UnitedHealthcare 1-800-842-9722</p> <p>For urgent care claims, specifically state that the claim is an urgent care claim.</p> <p>UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130</p>
<p>Express Scripts administered prescription drug benefit:</p> <ul style="list-style-type: none"> • HRA-Based Medical Plan • HSA-Based Medical Plan 	<ul style="list-style-type: none"> • For urgent care claims, your physician must submit the urgent care claim request by calling Express Scripts at 1-800-753-2851. • For nonurgent, pre-service, and concurrent care claims, your physician must submit the request electronically to Express Scripts. Information about electronic options can be found at express-scripts.com/PA. • For questions about the authorization process, call 1-855-388-0352.
<p>Fully insured medical plans (including Kaiser plan options and the UnitedHealthcare Group Medicare Advantage (PPO) Plan option)</p>	<p>For information, refer to your Evidence of Coverage, Summary Plan Description, or similar documentation provided directly from or made available to you by the insurer.</p>
<p>Delta Dental</p>	<p>Not applicable. For pretreatment estimates, see “Chapter 5: Retiree Dental Plan.”</p>
<p>Retirement Medical Allowance Account</p>	<p>Not applicable.</p>

Filing a post-service claim

Post-service claims must contain all the information described in this section (except for Retirement Medical Allowance Account claims, which are addressed in “[Chapter 4: Retirement Medical Allowance 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 on page A-7 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 provider will file a post-service claim on your behalf. However, you should always check with your 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 or while covered under the UnitedHealthcare Temporary Medicare Supplement Plan, you’re responsible for ensuring that the claim is filed correctly and on time, even if the provider offers to file the claim on your behalf. You must complete the appropriate claim form and provide an itemized original bill* from your 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; refer to your member ID card for the phone number of your claims administrator.

Claims for separate family members should be submitted separately. If you have other coverage that is “primary” and pays benefits before your benefit option under the Retiree Plan (for example, Medicare or another employer’s plan), you must submit your claim to such primary coverage before submitting a claim under the Retiree Plan. After the primary coverage has processed the claim and paid any benefits, you can then file your claim with the applicable claims administrator for the Retiree Plan. You must still file your claim under the Retiree Plan within the applicable time frame for filing claims. When you file your claim under the Retiree Plan, you must attach your Explanation of Benefits statement from your primary coverage.

Note: For the UnitedHealthcare Temporary Medicare Supplement Plan, you must attach a copy of the Explanation of Medicare Benefits statement to your claim for processing of all claims; also see the “UnitedHealthcare Temporary Medicare Supplement Plan — Medicare crossover, claims filing alternative” section on this page.

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.

UnitedHealthcare Temporary Medicare Supplement Plan — Medicare crossover, claims filing alternative

This section only applies if you are enrolled in the Wells Fargo-sponsored UnitedHealthcare Temporary Medicare Supplement Plan.

Medicare crossover is the process by which Medicare automatically forwards medical claims to UnitedHealthcare for processing. As a result, there is no need for you to file twice.

Based on agreements with the Medicare Part A and Part B claim processors, UnitedHealthcare can receive an electronic copy of your Explanation of Medicare Benefits statement directly from the Medicare processor. Upon receipt of the Explanation of Medicare Benefits statement, UnitedHealthcare will process your claim under the provisions of the applicable retiree medical plan. This eliminates the need for you or your provider to make a copy of the Explanation of Medicare Benefits statement and submit a second claim to UnitedHealthcare for Medicare Part A and Part B claim expenses.

To participate in the Medicare crossover program, you must contact UnitedHealthcare to authorize this service. Your covered dependent also can enroll for this program, as long as this plan is his or her only secondary medical coverage. UnitedHealthcare will coordinate the crossover setup with Medicare. You can verify that the automated crossover is in place when your copy of the Explanation of Medicare Benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears on your EOMB, you must continue to file your secondary claims directly with UnitedHealthcare by following the post-service claims filing requirements. For information about enrollment in the crossover process or if you have questions about the program, call the telephone number listed on the back of your ID card.

When the automated crossover process is in place, after your Medicare Part A and Part B claims are processed by Medicare, claims for expenses that Medicare has covered will be automatically sent to UnitedHealthcare for secondary claims filing. It is important to note that this crossover process does not apply to expenses that Medicare does not cover under Medicare Part A or Medicare Part B. Expenses that Medicare does not cover or considers ineligible are also ineligible for reimbursement under this plan.

Contacts for post-service claims

Benefit plan option	Contact	Time frame for claim submission
<ul style="list-style-type: none"> • HRA-Based Medical Plan • HSA-Based Medical Plan 	UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130 For prescription drug claims, refer to the information in the row titled “Express Scripts administered prescription drug benefit:” below.	<p>In-network providers: For services received from an in-network provider, the in-network provider is 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.</p> <p>Out-of-network providers: For services received from an out-of-network provider, you or the provider are required to file the claim within 12 months from the date of service.</p>
UnitedHealthcare Temporary Medicare Supplement Plan	UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130	12 months from date of service.
Express Scripts administered prescription drug benefit: <ul style="list-style-type: none"> • HRA-Based Medical Plan • HSA-Based Medical Plan 	Express Scripts Attn: Benefit Coverage Review Department PO Box 66587 St. Louis, MO 63166-6587 Fax: 1-877-328-9660	Claims must be received no later than 12 months from the date the prescription drug or covered supplies were dispensed.
Fully insured medical plans (including Kaiser plan options and the UnitedHealthcare Group Medicare Advantage (PPO) Plan option)	For information, refer to your Evidence of Coverage, Summary Plan Description, or similar documentation provided directly from or made available to you by the insurer.	
Delta Dental	Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120	<p>In-network services: For services received from an in-network provider, the in-network provider is required to file the claim within 12 months from the date of service.</p> <p>Out-of-network services: For services received from an out-of-network provider, you are responsible for filing the claim within 12 months from the date of service.</p>
Retirement Medical Allowance Account	Claims Administrator — HealthEquity PO Box 14053 Lexington, KY 40512 <ul style="list-style-type: none"> • Fax: 1-877-353-9236 • Scan and upload through https://participant.wageworks.com 	Claims for eligible expenses incurred during the plan year must be filed by the following April 30. Refer to “ Chapter 4: Retirement Medical Allowance Account ” for more information.

Claim determinations, determination extensions, and requests for additional information

If you have properly followed the claims procedure, the claims administrator will issue a written determination within a reasonable period of time but not later than the time frame listed in the “Initial claims procedures” 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

“Initial claims procedures” 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

Claim type	You will be notified of a determination:	Extension of time for the claims administrator to make a determination	If the claims administrator needs additional information:
Pre-service	Within a reasonable period of time, but not later than 15 days after receipt of the claim.	One extension period up to 15 days.	You will have at least 45 days from receipt of the notice to provide the requested information.
Pre-service involving urgent care	As soon as possible, but not later than 72 hours after receipt of the claim if no additional information is necessary. If additional information is necessary, you will be notified of a determination as soon as possible, but not later than 48 hours after the earlier of: (1) receipt of requested information or (2) the expiration of the time period given to provide the requested information.	None permitted.	You will be notified as soon as possible, but not later than 24 hours after receipt of the claim. You will then have at least 48 hours to provide the requested information.
Concurrent care: To end treatment prematurely or reduce treatment	At a time before treatment ends or is reduced that is sufficient to allow you to appeal the decision and receive a decision on appeal before the treatment ends or is reduced.	None permitted.	Not applicable.
Concurrent care: To request extension of treatment	Within a reasonable period of time, but not later than 15 days after receipt of the claim.	One extension period up to 15 days.	You will have at least 45 days from receipt of the notice to provide the requested information.
Concurrent care involving urgent care	As soon as possible, but within 72 hours after receipt of the claim, provided that such claim is received at least 72 hours before the expiration of the prescribed number of treatments or period of time.	None permitted.	You will be notified as soon as possible, but not later than 24 hours after receipt of the claim. You will then have at least 48 hours to provide the requested information.
Post-service	Within a reasonable period of time, but not later than 30 days after receipt of the claim.	One extension period up to 15 days.	You will have at least 45 days to provide the information.

Content of the claim determination notice

Regardless of the type of claim, you will receive a notice of any adverse benefit determination in written or electronic form. The notice will provide the following information:

- The specific reason or reasons for the adverse determination
- Reference to the specific plan provisions on which the determination is based
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary
- A description of the plan's claim review procedures and a statement regarding your right to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended (ERISA) Section 502(a) following an adverse benefit determination on appeal
- If applicable, a statement indicating the internal rule, guideline, or protocol that was relied upon to make the adverse determination and that a copy of such rule, guideline, or protocol 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
- 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. 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 appeal review without first calling the plan's member services department.

You must file an 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

If you disagree with an adverse benefit determination on a claim, you have the right to have your adverse benefit determination reviewed on appeal. You must file your appeal with the applicable claims administrator within 180 days from the date you receive the adverse benefit determination notification, regardless of any discussions or consultations that have occurred regarding your claim. Generally, you must exhaust the appeal process before bringing a civil action under Section 502(a) of ERISA.

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 Retiree 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 Retiree Plan as directed by the claims administrator. If there is no patient liability for the claim, there is no appeal option under the Retiree Plan.

Authorizing a representative

An authorized representative is an individual you have authorized in accordance with the Plan's requirements to file claims and appeals on your behalf.

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 appeal process, most claims administrators require that you submit a written authorization to them on their approved form*. You can call the claims administrator to request an authorization form. However, if the claims administrator does not require you to complete a specific form, simply submit a written authorization statement with your appeal. Your authorization statement must specify:

- The name and address of the person authorized to represent you
- The purpose for which 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

* 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 page A-11.

Filing an appeal

You must file an appeal with the applicable claims administrator within 180 days of the date you receive the adverse benefit determination notification, regardless of any discussions or consultations regarding the claim. Your failure to comply with this important deadline may cause you to forfeit any right to any further review under these claims and appeals procedures or in a court of law.

Urgent 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 notification. For the address to which an urgent care claim or concurrent care claim appeal should be submitted, refer to the “[Contacts for urgent care claim and concurrent claim appeals](#)” table on page A-12. 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-13.

The time period for providing notice of an appeal determination varies by the type of claim as described below.

Type of claim appeal	You will be notified of a determination:
Urgent care	As soon as possible, but not later than 72 hours from receipt of the appeal
Pre-service	Within a reasonable period of time, but not later than 30 days from receipt of the appeal
Concurrent care	In the appeal time frame for pre-service, urgent care, or post-service claims as appropriate to the request
Post-service	Within a reasonable period of time, but not later than 60 days from receipt of the appeal

The applicable time periods begin to run when the appeal is received, regardless of whether the claims administrator has all of the information necessary to decide the appeal. If you want to provide the claims administrator with more time, in addition to the applicable time period, to make a determination after the appeal is received, you may voluntarily agree to an extension by contacting the claims administrator.

To assist in the preparation of your appeal, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your initial claim, as noted below. However, a request for documentation does not extend the time period allowed for you to file an appeal.

To obtain a copy of the claim file and other documents or records the claims administrator may have related to your claim, send your written request to the applicable claims administrator. 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 table below.

Claims administrator	Address
UnitedHealthcare	UnitedHealthcare PO Box 30884 Salt Lake City, UT 84130
Express Scripts	Express Scripts Attn: Commercial Claims PO Box 14711 Lexington, KY 40512-4711
Delta Dental	Delta Dental of Minnesota PO Box 30416 Lansing, MI 48909
HealthEquity	HealthEquity Claims Department PO Box 14053 Lexington, KY 40512

To obtain a copy of the SPD, go to <https://benefitconnect.wf.ehr.com/ESS>. 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 retiree's name and date of birth, the plan name, and calendar year or 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-9 for more information).

Information needed for the appeal

Submit the following information with your appeal:

- Patient's name, date of birth, and relationship to the participant or retiree
- 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 claim appeals

Benefit plan option	Contact
<ul style="list-style-type: none"> • HRA-Based Medical Plan • HSA-Based Medical Plan 	<p>UnitedHealthcare 1-800-842-9722</p> <p>For urgent care claim appeals, specifically state that the appeal is an urgent care claim appeal.</p> <p>For prescription drug claim appeals, refer to the information in the row titled “Express Scripts administered prescription drug benefit:” below.</p>
<p>UnitedHealthcare Temporary Medicare Supplement Plan (prescription drug coverage only)</p> <p>Note: There are no urgent care or concurrent care claim requirements for medical claims under the UnitedHealthcare Temporary Medicare Supplement Plan.</p>	<p>UnitedHealthcare Appeals PO Box 740816 Atlanta, GA 30374-0816</p>
<p>Express Scripts administered prescription drug benefit:</p> <ul style="list-style-type: none"> • HRA-Based Medical Plan • HSA-Based Medical Plan 	<p>Express Scripts</p> <ul style="list-style-type: none"> • Urgent Care Claim appeal <ul style="list-style-type: none"> – Your physician must submit the urgent care claim appeal request by calling 1-800-753-2851. – If you have questions, call customer service at 1-855-388-0352. • Nonurgent or Concurrent Care Claim appeal <p>Express Scripts Attn: Clinical Appeals Department PO Box 66588 St. Louis, MO 63166-6588 Fax: 1-877-852-4070</p>
<p>Fully insured medical plans (including Kaiser plan options and the UnitedHealthcare Group Medicare Advantage (PPO) Plan option)</p>	<p>For information, refer to your Evidence of Coverage, Summary Plan Description, or similar documentation provided directly from or made available to you by the insurer.</p>
<p>Delta Dental</p>	<p>Not applicable. For pretreatment estimates, see “Chapter 5: Retiree Dental Plan.”</p>
<p>Retirement Medical Allowance Account</p>	<p>Not applicable.</p>

Contacts for pre- and post-service claim appeals

Benefit plan option	Address
<ul style="list-style-type: none"> • HRA-Based Medical Plan • HSA-Based Medical Plan 	UnitedHealthcare Appeals PO Box 740816 Atlanta, GA 30374-0816 For prescription drug claim appeals, refer to the information in the row titled “Express Scripts administered prescription drug benefit.” below.
UnitedHealthcare Temporary Medicare Supplement Plan: <ul style="list-style-type: none"> • Medical post-service claim appeals • Prescription drug coverage pre-service and post-service claim appeals 	UnitedHealthcare Appeals PO Box 740816 Atlanta, GA 30374-0816
Express Scripts administered prescription drug benefit: <ul style="list-style-type: none"> • HRA-Based Medical Plan • HSA-Based Medical Plan 	<ul style="list-style-type: none"> • Pre-Service Claim appeal Express Scripts Attn: Clinical Appeals Department PO Box 66588 St. Louis, MO 63166-6588 Fax: 1-877-852-4070 • Post-Service Claim appeal Express Scripts Attn: Administrative Appeals Department PO Box 66587 St. Louis, MO 63166-6587 Fax: 1-877-328-9660
Fully insured medical plans (including Kaiser plan options and the UnitedHealthcare Group Medicare Advantage (PPO) Plan option)	For information, refer to your Evidence of Coverage, Summary Plan Description, or similar documentation provided directly from or made available to you by the insurer.
Delta Dental Note: Post-service claim appeals only, there are no pre-service claim requirements.	Delta Dental of Minnesota PO Box 30416 Lansing, MI 48909
Retirement Medical Allowance Account Note: Post-service claim appeals only, there are no pre-service claim requirements.	HealthEquity Claims Appeal Board PO Box 34700 Louisville, KY 40232 Fax: 1-866-843-2219

The 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.

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 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
- Any additional information required under applicable law

The claims administrator's appeal determination is the final determination.

Legal action

No legal action can be taken against any party with regard to a claim for benefits under the plan options of the Wells Fargo & Company Retiree Plan (Retiree Plan) to which the procedures in this appendix apply until the procedures described in the "[Claims](#)" section starting on page A-2 and the "[Appealing an adverse benefit determination](#)" section starting on page A-9 have been exhausted. Any suit for benefits must be brought within the earlier of: (i) one year from the date a final determination is made under the Retiree Plan with regard to the claim for benefits or should have been made in accordance with the Retiree Plan's claims review procedures or (ii) three years from the date the service or treatment was provided. Refer to the "[Agent for service](#)" section in "Appendix B: Important Notifications and Disclosures" for more information.

Appendix B: Important Notifications and Disclosures

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Your rights under ERISA

All of the Wells Fargo-sponsored plans listed in the “[ERISA plans sponsored by Wells Fargo](#)” table on page B-5 are subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA gives you rights as a participant in these plans.

Receive information about your plan and benefits

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

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

Continue group health plan coverage

You may be entitled to continue health care coverage for your spouse or your dependents if there is a loss of coverage under a Wells Fargo-sponsored group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review “[Appendix E: Continuing Coverage Under COBRA](#)” in this *Retiree 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 benefits 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 certain steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and you have exhausted the claims procedure for the plan, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

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

Assistance with your questions

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

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

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

Other notifications for retiree group health plan coverage

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

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).

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 on page B-5 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 on page B-5. Please use the address below for any correspondence to the plan sponsor and include the plan name and plan number in your correspondence:

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

Plan administrator

The plan administrator for all plans listed in the "[ERISA plans sponsored by Wells Fargo](#)" table on page B-5, for purposes of ERISA §3(16)(A), is the Director of Human Resources and the Director of Compensation and Benefits of Wells Fargo & Company, each of whom, acting individually or jointly, may take action as the plan administrator for the respective plan. The plan administrator has full discretionary authority to administer and interpret those plans. The plan administrator may delegate duties and authority to others to accomplish those duties.

The plan administrator's address is:

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

To contact the plan administrator, you may also call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

The insurer of each "insured" ERISA plan sponsored by Wells Fargo & Company has sole and complete discretionary authority to administer and interpret the provisions of the plan it insures. Please see the "[ERISA plans sponsored by Wells Fargo](#)" table on page B-5 to determine whether a plan is insured and for corresponding contact information for the applicable insurer or claims administrator.

Agent for service

Wells Fargo & Company's Corporate Secretary, at the address listed below, is the designated agent for service of the 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 on page B-5.

No legal action can be taken against any party with regard to a claim for benefits under the Wells Fargo & Company Retiree Plan (Retiree Plan) until the applicable claims and appeals procedures described in this *Retiree Benefits Book* have been exhausted. Any suit for benefits must be brought within the earlier of: (i) one year from the date a final determination (or deemed final determination) is made under the Retiree Plan with regard to the claim for benefits or should have been made in accordance with the Retiree Plan's claims review procedures or (ii) three years from the date the service or treatment was provided.

No legal action can be taken with regard to a claim for benefits under the Wells Fargo & Company Retiree Life Insurance Plan until the Retiree Life Insurance Plan's claims and appeals procedures have been exhausted.

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

Plan trustee

The plan trustee for the Wells Fargo & Company Retiree Plan 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.

Disclosure about health savings accounts

Wells Fargo & Company sponsors and maintains a high-deductible health plan, the HSA-Based Medical Plan, for plan participants and their eligible dependents that is 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.
- Wells Fargo & Company does not make or influence the investment decisions with respect to funds contributed to an HSA. Available HSA investment funds are not guaranteed and you could lose money.
- Wells Fargo & Company does not represent that the HSA is an ERISA-covered employee benefit plan established or maintained by Wells Fargo & Company or any of its subsidiaries or affiliates.

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

Participating employers

The plans generally cover retirees 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 plan administrator at the address listed in the “[Plan administrator](#)” section on page B-3.

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, covered spouses or domestic partners, covered dependents, and beneficiaries.

Plan amendments

Wells Fargo & Company, by action of its Board of Directors, the Human Resources Committee of the Board of Directors, or that of a person so authorized by resolution of the Board of Directors or the Human Resources Committee, may amend the plans at any time, for any reason, with or without notice. In addition, Wells Fargo & Company’s Director of Human Resources or Director of Compensation and Benefits or their delegate may amend the plans to comply with changes in applicable law, add or amend exhibits to the plans, or make changes in the administration or operation of the plans.

Plan termination

Wells Fargo & Company may terminate any plan at any time, for any reason, with or without notice by action of Wells Fargo’s Board of Directors. Wells Fargo & Company, by written action of its President, Chief Executive Officer, Director of Human Resources, or Director of Compensation and Benefits or their delegate (subject to any limitations specified in applicable resolutions adopted by the Board of Directors of the Company), may terminate any plan at any time, for any reason, with or without notice, as it applies to any participating employer.

ERISA plans sponsored by Wells Fargo

Name of plan	Plan or coverage option	Plan number	Service provider or insurer
Wells Fargo & Company Retiree Plan	Health Reimbursement Account (HRA)-Based Medical Plan* (Self-insured ¹) * Including Out of Area coverage	504	Medical UnitedHealthcare 1-800-842-9722 Prescriptions Express Scripts 1-855-388-0352
Wells Fargo & Company Retiree Plan	Health Savings Account (HSA) ² -Based Medical Plan (Self-insured ¹)	504	Medical UnitedHealthcare 1-800-842-9722 Prescriptions Express Scripts 1-855-388-0352
Wells Fargo & Company Retiree Plan	UnitedHealthcare Group Medicare Advantage PPO Plan (Insured ³)	504	UnitedHealthcare 1-800-430-5471
Wells Fargo & Company Retiree Plan	UnitedHealthcare Temporary Medicare Supplement Plan (Self-insured ¹)	504	UnitedHealthcare 1-800-842-9722
Wells Fargo & Company Retiree Plan	HMO — Kaiser Northern California (Insured ³)	504	Kaiser Permanente 1-800-464-4000
Wells Fargo & Company Retiree Plan	HMO — Kaiser Southern California (Insured ³)	504	Kaiser Permanente 1-800-464-4000
Wells Fargo & Company Retiree Plan	Kaiser Senior Advantage — Northern California (Medicare Advantage Plan) (Insured ³) and Kaiser Senior Advantage — Southern California (Medicare Advantage Plan) (Insured ³)	504	Kaiser Permanente 1-800-443-0815
Wells Fargo & Company Retiree Plan	POS Kaiser Added Choice — Hawaii (Insured ³)	504	Kaiser Permanente 1-800-966-5955
Wells Fargo & Company Retiree Plan	Delta Dental Plan (Self-insured ¹)	504	Delta Dental of Minnesota 1-877-598-5342
Wells Fargo & Company Retiree Plan	Vision Service Plan (VSP) (Self-insured ¹)	504	VSP 1-877-861-8352
Wells Fargo & Company Retiree Plan	Wells Fargo & Company Retirement Medical Allowance Account (RMAA)	504	HealthEquity 1-877-924-3967
Wells Fargo & Company Retiree Plan	Prudential Securities Inc. Retirement Medical Allowance (PSI RMA)	504	HealthEquity 1-877-924-3967
Wells Fargo & Company Retiree Life Insurance Plan	Retiree Life Insurance Plan (Insured ³)	536	Metropolitan Life Insurance Company (MetLife) Wells Fargo Retirement Service Center 1-877-HRWELLS (1-877-479-3557), option 1

1. “Self-insured” means benefits are paid for by the Wells Fargo & Company Retiree Plan through a trust. The identified service provider provides claims administrative services and is the claims and appeals fiduciary.

2. 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.

3. “Insured” means benefits are fully insured and paid for by the insurer, which may be an HMO or a Group Medicare Advantage Plan.

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Appendix C: Health Savings Accounts

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Introduction

Please note that this appendix is included in the overall *Retiree 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 Retiree Plan (or its benefit options, including the HSA-Based Medical Plan) or for any ERISA-covered employee benefit plans maintained by Wells Fargo & Company.

This appendix to the *Retiree 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. In particular, and except as otherwise indicated, this appendix will address the HSA and not the associated high-deductible health plan.

Optum Bank provides certain HSA administrative services.

Wells Fargo does not insure the HSAs described in this appendix. It is Wells Fargo's intention to comply with U.S. Department of Labor guidance set forth in Field Assistance Bulletin Numbers 2004-01 and 2006-02, which specifies that an HSA is not subject to ERISA when the employer's involvement is limited.

Establishment of an HSA is completely voluntary on your part:

- Wells Fargo does not limit your ability to move your funds to another HSA or impose conditions on usage of HSA funds beyond those permitted under the Internal Revenue Code of 1986.
- 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 Wells Fargo.

An HSA is an individually owned account. Your HSA will continue to be your account, even if you change your medical plan.

About the HSAs

An HSA is a tax-advantaged savings vehicle funded by you, your former employer, or any other person on your behalf. An HSA can help you to cover, on a tax-free basis, qualified medical expenses that you pay out of pocket, such as deductibles or coinsurance. It may be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay nonmedical expenses; however, these amounts are subject to income tax and may be subject to an additional 20% tax. There are specific requirements for opening an HSA and making contributions to it as described later in this appendix, including enrolling in a high-deductible health plan.

Note: Tax references are at the federal level. Some state taxes may apply. Please consult a tax advisor.

What is an HSA?

An HSA is a tax-advantaged savings vehicle that participants in the HSA-Based Medical Plan can use to pay for qualified medical expenses that they or their spouse and eligible dependents incur. After you lose eligibility to contribute to an HSA, you can continue to use your HSA to pay for expenses (even those incurred after the coverage stopped), but you will not be able to continue to make contributions.

HSA funds at Optum Bank:

- Accumulate in an interest-bearing deposit account and may be invested* once you reach the designated balance for your HSA
- Are portable
- Can be used to pay for qualified medical expenses tax-free or for nonmedical expenses on a taxable basis (are subject to income tax and may be subject to an additional 20% tax)

* INVESTMENT PRODUCTS: NOT FDIC INSURED, NO BANK GUARANTEE, MAY LOSE VALUE

Who is eligible to open and contribute to an HSA

Who is eligible to contribute to an HSA

You must be covered under a Wells Fargo-sponsored high-deductible health plan to contribute to an HSA. Eligibility to participate in the HSA-Based Medical Plan is described in [“Chapter 1: Eligibility, Enrollment, and More.”](#)

You cannot contribute to an HSA if:

- 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 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. 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” flexible spending account (FSA) or health reimbursement account (HRA) will not make you ineligible. A “limited purpose” FSA or HRA typically covers only dental, vision, preventive care, or post-deductible expenses.
- You have received medical benefits from the Department of Veterans Affairs (VA) at any time during the previous three months (with an exception starting in 2016 for receipt of VA hospital care or medical services in connection with a service-related disability).
- You have received medical services at an Indian Health Service (IHS) facility at any time during the previous three months.

Note: You are responsible for determining if you are eligible to contribute to an HSA. Consult a tax advisor with questions.

How to open an HSA

If you enroll in the HSA-Based Medical Plan through the Wells Fargo & Company Retiree Plan, 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 a home phone number by contacting the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.
- 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 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 2021 tax year, the maximum HSA contribution is:
 - \$3,600 for people with individual coverage
 - \$7,200 for people with family coverage
- If you are age 55 or older, you may contribute an additional \$1,000 per year to your HSA.

For more information about the maximum limits set by federal 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 federal regulations 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 may face tax consequences. Consult a tax advisor to determine how midyear eligibility changes affect your contribution limit.

Note: Amounts that exceed your personal contribution maximum are not tax-deductible and will be subject to a 6% excise tax. This excise tax can be avoided if you withdraw the excess contribution (and net income attributable to such contribution) before the last day for filing your federal income tax return for the year (generally April 15 of the following year).

If you have contributed amounts in excess of the allowable maximum contribution, please call Optum Bank Customer Care at 1-844-326-7967.

Wells Fargo does not monitor whether you have exceeded your personal contribution limit. You are solely responsible for monitoring your personal contribution limit. Consult a tax advisor with questions.

Contributing through Optum Bank

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>.

Note: All funds placed into your HSA are owned and controlled by you and are 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 the HSA-Based 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.

Effective January 1, 2020, and as a result of the CARES Act, certain over-the-counter drugs and medicines, like aspirin and pain relievers, are eligible for payment or reimbursement from an HSA. Menstrual care products are also considered qualified medical expenses for HSAs.

Examples of what constitutes “qualified medical expenses” are available in IRS Publication 502, which is available from any regional IRS office or the IRS website. They are also available at <https://www.optumbank.com>. Note that Publication 502 lists expenses that are deductible — which aren’t necessarily the same as expenses that are HSA-eligible. For example, although taxpayers may deduct health insurance premiums on their

tax returns if certain requirements are met, reimbursement of such premiums through an HSA is restricted. HSAs may only reimburse limited categories of insurance premiums on a tax-favored basis (such as COBRA coverage or health insurance for an accountholder who is age 65 or older, but excluding premiums for Medigap policies).

Important

Be sure to keep your receipts and medical records. If these records verify that you paid qualified medical expenses using your HSA, you can exclude these HSA distributions from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified medical expenses, you may need to report the distribution as taxable income on your tax return. Wells Fargo does not verify that distributions from your HSA are for qualified medical expenses. Consult a tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Wells Fargo is not responsible for maintaining receipts or responsible if you use HSA funds for nonqualified medical expenses.

Using the HSA for nonqualified expenses

A nonqualified medical expense is generally one that is not eligible under Section 213(d) of the Code. Any funds used from your HSA to pay for nonqualified expenses will be subject to income tax and a 20% additional tax unless an exception applies to the additional tax (that is, your death, your disability, or your attainment of age 65). In general, you may not use your HSA to pay for health insurance premiums without incurring an income tax and a penalty tax. (You may use your HSA to pay for COBRA, Medicare, and certain other premiums, but not premiums for Medigap policies.)

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 enrollment in the HSA-Based Medical Plan ends, you will continue to own and control the funds in your HSA.

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 the retiree continues to be enrolled in the Wells Fargo & Company Retiree HSA-Based 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>. If the retiree is no longer enrolled in the Wells Fargo-sponsored HSA-Based Medical Plan, Wells Fargo will not pay the monthly service fee and the retiree will be responsible for the monthly service fee and all other fees for the HSA.

You can obtain additional information about HSA online at https://www.irs.gov/publications/p969/ar02.html#en_US_publink1000204020 or at <https://www.optumbank.com>. You may also contact a tax advisor. Optum Bank Customer Care can be contacted at 1-844-326-7967.

Note: The tax rules for HSAs are complex. This appendix only describes some of the rules. You should review information provided by Optum Bank and the IRS, as well as the Code provisions for HSAs. Wells Fargo does not provide tax advice, and you may want to consult with a tax advisor. All tax references are at the federal level; state taxes may vary.

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Appendix D: Retiree Group Tables

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Retiree medical subsidies effective January 1, 2017, for participants eligible for Medicare

As of January 1, 2017, retiree medical subsidies were adjusted for certain retirees eligible for Medicare. These subsidies were adjusted to align with the reduced premium of the UnitedHealthcare (UHC) Group Medicare Advantage PPO Plan introduced in 2017. In addition, retiree medical subsidies were adjusted for certain retirees eligible for Medicare to consolidate the number of subsidy tiers. Unless otherwise specified in the tables beginning on page D-3, the subsidy changes for certain participants eligible for Medicare were determined using the following methodologies:

Subsidy: Based on a percentage of the cost of the UHC Group Medicare Advantage Plan

The adjusted subsidy amount was determined by taking the 2016 subsidy amount and converting that amount to a percentage of the 2016 retiree premium. The new percentage was rounded up to the next subsidy percentage tier (for example, 10%, 30%, 45%, 65%, 70%, 75%, 80%, 85%, 90%, 95%, 100%).

Subsidy: Retiree pays a fixed amount

The adjusted subsidy amount was determined by rounding the 2016 fixed monthly payment for retiree-only coverage down to the nearest tier amount (for example, \$10, \$15, \$25, \$55, \$80, \$90, \$110, \$140), with an equal fixed amount for eligible dependents.

Subsidy: Company pays a fixed amount (all groups except former Wells Fargo Financial)

The adjusted subsidy amount was determined by rounding up the 2016 subsidy amount up to the nearest \$25 increment and then reducing the result by 40%.

Subsidy: Company pays a fixed amount (former Wells Fargo Financial)

The adjusted subsidy amount was determined by rounding the 2016 subsidy amount up to the next \$25 increment and then reducing the result by 10%.

Additional important information

For retiree groups eligible to receive a subsidy for eligible spouses or domestic partners, subsidies are only available if coverage was elected for the spouse or domestic partner at the initial retiree medical election. If there is a Qualified Event after that initial election, new eligible dependents may be added to coverage, but a subsidy will not be available for them.

In no case can a retiree (or the surviving dependent of a retiree) have more than one Wells Fargo & Company Retiree Plan medical subsidy. Retiree medical subsidies include those that are applied to the cost of coverage under a Wells Fargo & Company retiree medical plan and described in “Appendix D: Retiree Group Tables,” as well as subsidies described in “[Chapter 4: Retirement Medical Allowance Account](#)” and in the Prudential Securities, Inc. Retirement Medical Allowance (PSI RMA) Summary Plan Description. To receive a copy of the PSI RMA Summary Plan Description, you may call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1.

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
A	<ul style="list-style-type: none"> • Retiree as of 1/1/1993 of either: <ul style="list-style-type: none"> – The former Wells Fargo* – The former First Interstate • Age 65 and over as of that date 	Yes, retiree pays active rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
A1	<ul style="list-style-type: none"> • Retiree as of 1/1/1993 of either: <ul style="list-style-type: none"> – The former Wells Fargo* – The former First Interstate • Age 65 and over as of that date • Enrolled in the former Core or Core Excess Plan as of 12/31/2007 	Yes, retiree pays active rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
B	<ul style="list-style-type: none"> • Retiree as of 1/1/1993 of either: <ul style="list-style-type: none"> – The former Wells Fargo* – The former First Interstate • Under age 65 as of that date 	Yes, retiree pays active rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
B1	<ul style="list-style-type: none"> • Retiree as of 1/1/1993 of either: <ul style="list-style-type: none"> – The former Wells Fargo* – The former First Interstate • Under age 65 as of that date • Enrolled in the former Core or Core Excess Plan as of 12/31/2007 	Yes, retiree pays active rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan

* “Former Wells Fargo” refers to employees of the former Wells Fargo & Company and its subsidiaries.

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
C	<ul style="list-style-type: none"> Employee of the former Wells Fargo* on 1/1/1993 and on this date had: <ul style="list-style-type: none"> At least 10 years of service as measured from the adjusted service date or corporate hire date, whichever was earlier Reached at least age 55 <p>Or</p> <ul style="list-style-type: none"> Employee of the former First Interstate on 1/1/1997 and on this date had: <ul style="list-style-type: none"> At least 10 years of service as measured from the adjusted service date or corporate hire date, whichever was earlier Reached at least age 55 <p>And</p> <ul style="list-style-type: none"> On last day of employment: <ul style="list-style-type: none"> You must be 55 years or older with 10 or more years of service as measured from the adjusted service date or corporate hire date (whichever is earlier; partial years are not considered). Have been continually employed by Wells Fargo since 1/1/1993 or by the former First Interstate since 1/1/1997. Breaks in service of more than six months terminate eligibility for a retiree medical subsidy. 	<ul style="list-style-type: none"> Yes, annual subsidy of \$140 × years of service for retiree, 25 years maximum Annual subsidy of \$140 × retiree's years of service, 25 years maximum, for eligible spouse or domestic partner, if coverage was elected for spouse or domestic partner at initial retiree medical election For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015 A minimum monthly premium charge of \$35 per adult will apply 	<p>Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan for retiree and eligible spouse or domestic partner, if coverage was elected for spouse or domestic partner at initial retiree medical election. A different subsidy is applied depending on whether retirement date was before or after 7/1/1999.</p>

* "Former Wells Fargo" refers to employees of the former Wells Fargo & Company and its subsidiaries.

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
C1	<ul style="list-style-type: none"> Employee of the former Wells Fargo* on 1/1/1993 <ul style="list-style-type: none"> With 10 years of service as measured from the adjusted service date or corporate hire date, whichever is earlier At least 55 years old Eligible to retire on 1/1/1993 	<ul style="list-style-type: none"> Yes, annual subsidy of \$140 × years of service for retiree and spouse, 25 years maximum A minimum monthly premium charge of \$35 per adult will apply 	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan; a different subsidy is applied depending on whether retirement date was before or after 7/1/1999
	<p>Or</p> <ul style="list-style-type: none"> Employee of the former First Interstate on 1/1/1997 <ul style="list-style-type: none"> With 10 years of service as measured from the adjusted service date or corporate hire date, whichever is earlier At least 55 years old Eligible to retire on or before 1/1/1997 		

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
D	<ul style="list-style-type: none"> Employee of the former Wells Fargo* with a hire date before 10/1/1992 but was not at least age 55 with at least 10 years of service on 1/1/1993 <p>Or</p> <ul style="list-style-type: none"> Employee of the former First Interstate with a hire date before 1/1/1992 but was not at least age 55 with at least 10 years of service on 1/1/1997 <p>And</p> <ul style="list-style-type: none"> You must be at least age 55 with at least 10 years of service as of the last day of employment to be eligible for a subsidy. Service is defined as full years of employment as measured from the corporate hire date or the adjusted service date, whichever is earlier. Have been continually employed by Wells Fargo since 1/1/1993 or by the former First Interstate since 1/1/1997. Breaks in service of more than six months terminate eligibility for a retiree medical subsidy. 	<ul style="list-style-type: none"> Yes, annual subsidy of \$140 × years of service for retiree, 25 years maximum Annual subsidy of \$140 × retiree's years of service, 25 years maximum, for eligible spouse or domestic partner, if coverage was elected for spouse or domestic partner at initial retiree medical election For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015 A minimum monthly premium charge of \$35 per adult will apply 	None, there is no subsidy once you become eligible for Medicare
* "Former Wells Fargo" refers to employees of the former Wells Fargo & Company and its subsidiaries.			
AA	<ul style="list-style-type: none"> Norwest retiree retired before 1/1/1990 <ul style="list-style-type: none"> With at least 15 years of credited service under the Norwest Corporation Pension Plan At least 55 years old at the time of retirement 	Yes, retiree pays active rates	Yes, company pays 100%
AB	<ul style="list-style-type: none"> Norwest retiree retired between 1/1/1990 and 6/30/1999 <ul style="list-style-type: none"> With at least 15 years of credited service under the Norwest Corporation Pension Plan At least 55 years old at the time of retirement 	Yes, calculated using Age and Service Matrix or Transition Table (no minimum payment)	Yes, subsidy is a fixed amount

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
AC	<ul style="list-style-type: none"> Employee of former Norwest on 6/30/1999 <ul style="list-style-type: none"> On this date, had reached at least 45 years of age with at least five years of credited service under the Norwest Corporation Pension Plan Have been continuously employed since that time As of last day of employment on or after 7/1/1999: <ul style="list-style-type: none"> Must be 55 years or older With at least 15 years of service Service is calculated by combining: <ul style="list-style-type: none"> Credited service under the Norwest Corporation Pension Plan through 6/30/1999. Credited service under Wells Fargo & Company Cash Balance Plan from 7/1/1999 to 6/30/2009. Continuous employment with Wells Fargo & Company from 7/1/2009 to last day of employment or 12/31/2015, whichever is earlier. Breaks in service of more than six months terminate eligibility for a retiree medical subsidy. 	<ul style="list-style-type: none"> Yes, variable based on the greater of either the AC Age and Service Matrix or annual subsidy of \$140 × years of service for retiree, 25 years maximum Annual subsidy is the greater of the Norwest 45 and 5 Age and Service Matrix or \$140 × years of service, 25 years maximum, for eligible spouse or domestic partner, if coverage was elected for spouse or domestic partner at initial retiree medical election For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015 A minimum monthly premium charge of \$35 per adult will apply 	<p>Yes, subsidy is a fixed amount</p> <p>For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015</p> <p>A minimum monthly premium charge of \$35 per adult will apply</p>

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
AD	<ul style="list-style-type: none"> Employee of former Norwest on 6/30/1999 and on this date had: <ul style="list-style-type: none"> Not yet reached age 45 or did not have at least five years of credited service under the Norwest Corporation Pension Plan As of last day of employment on or after 7/1/1999: <ul style="list-style-type: none"> Must be 55 years or older With at least 15 years of service Service is calculated by combining: <ul style="list-style-type: none"> Credited service under the Norwest Corporation Pension Plan through 6/30/1999. Credited service under Wells Fargo & Company Cash Balance Plan from 7/1/1999 to 6/30/2009. Continuous employment with Wells Fargo & Company from 7/1/2009 to last day of employment or 12/31/2015, whichever is earlier. Breaks in service of more than six months terminate eligibility for a retiree medical subsidy. 	<ul style="list-style-type: none"> Yes, annual subsidy of \$140 × years of service for retiree, 25 years maximum Annual subsidy of \$140 × years of service, 25 years maximum, for eligible spouse or domestic partner, if coverage was elected for spouse or domestic partner at initial retiree medical election For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015 A minimum monthly premium charge of \$35 per month will apply 	<ul style="list-style-type: none"> Yes, subsidy is a fixed amount For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015 A minimum monthly premium charge of \$35 per month will apply
AH	Davenport Bank & Trust retiree	Yes, retiree pays a fixed amount	Yes, retiree pays a fixed amount
AI	First Interstate Northern Indiana retiree	Yes, company pays 100%	Yes, company pays 100%
AJ	First Illini Bancorporation retiree	None	None
AL	First Interstate Wisconsin (FIWI) retiree	Yes, subsidy is a fixed amount	Yes, subsidy is a fixed amount
AO	Lincoln Financial retiree	Yes, subsidy is a fixed amount	Yes, subsidy is a fixed amount
AP	Acquisition of former Norwest, retired prior to 11/1/1985	Yes, company pays 100%	Yes, company pays 100%

Medical

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
AR	United Bank of Colorado retiree	Yes, subsidy is one of the following: 100%, 75%, 50%, or 0% of \$87 per month	Yes, subsidy is a fixed amount
AZ	Retiree of various Norwest acquired banks <ul style="list-style-type: none"> • Fridley State Bank • Merchants and Miners • Peoples Bank Waterloo 	Yes, subsidy is a fixed amount	Yes, subsidy is a fixed amount
BA	Michigan Financial retiree	None	Yes, company pays 100%
BB	First National Bank of Alaska retiree	Yes, retiree pays active rates	Yes, subsidy is a fixed amount
BH	Acordia, retired before 1/1/2002	Yes, for retiree only, subsidy is a fixed amount	Yes, for retiree only, subsidy is a fixed amount
BI	Employee of the former Acordia, retired on or after 1/1/2002, and must meet one of the following criteria as of the last day of employment: <ul style="list-style-type: none"> • At least age 55 with at least 10 years of service. • Age 65 with at least one year of service. • At least 80 points (based on age plus full years of service). • Breaks in service of more than six months terminate eligibility for a retiree medical subsidy. 	Yes, for retiree only, subsidy is a fixed amount	Yes, for retiree only, subsidy is a fixed amount
BK	Wells Fargo Financial, retired before 1993	Yes, subsidy is built into rates	Yes, subsidy is a fixed amount
BL	Wells Fargo Financial, retired between 1993 and 2005	Yes, calculated using the BP Age and Service Matrix	Yes, subsidy is a fixed amount

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
BP*	<p>Employee of former Wells Fargo Financial with a hire date prior to 1/1/2003, but was not yet 55 years old and with at least five years of service as of 12/31/2004 or had fewer than 60 points as of 12/31/2004 (points are measured as one point for each year of age and one point for each full year of service)</p> <p>And</p> <ul style="list-style-type: none"> You must be at least age 55 with at least 10 years of service as of the last day of employment to be eligible for a subsidy <p>Service is calculated by combining:</p> <ul style="list-style-type: none"> Credited service under the Wells Fargo Financial Pension Plan (formerly Norwest Financial) as of 12/31/2004. Credited service under the Wells Fargo & Company Cash Balance Plan from 1/1/2005 to 6/30/2009. Continuous employment with Wells Fargo & Company from 7/1/2009 to last day of employment or 12/31/2015, whichever is earlier. Breaks in service of more than six months terminate eligibility for a retiree medical subsidy. 	<ul style="list-style-type: none"> Yes, calculated using the BP Age and Service Matrix for retiree and eligible dependents, if coverage was elected for eligible dependent at initial retiree medical election For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015 	<ul style="list-style-type: none"> Yes, subsidy is a fixed amount For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015

*Does not include members of Group BP who are members of Group PQ.

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
BQ	<ul style="list-style-type: none"> Employee of former Wells Fargo Financial with hire date before 1/1/2003 and as of that date had: <ul style="list-style-type: none"> Reached at least 55 years of age At least five years of credited service as of 12/31/2004 <p>Or</p> <ul style="list-style-type: none"> Had at least 60 points based on age and credited service <p>And</p> <ul style="list-style-type: none"> You must be at least age 55 with at least 10 years of service as of the last day of employment to be eligible for a subsidy <p>Service is calculated by combining:</p> <ul style="list-style-type: none"> Credited service under the Wells Fargo Financial Pension Plan (formerly Norwest Financial) as of 12/31/2004. Credited service under the Wells Fargo & Company Cash Balance Plan from 1/1/2005 to 6/30/2009. Continuous employment for Wells Fargo & Company from 7/1/2009 to last day of employment or 12/31/2015, whichever is earlier. Breaks in service of more than six months terminate eligibility for a retiree medical subsidy. 	<ul style="list-style-type: none"> Yes, calculated using the BQ Age and Service Matrix for retiree and eligible dependents, if coverage was elected for eligible dependent at initial retiree medical election For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015 	<ul style="list-style-type: none"> Yes, subsidy is a fixed amount For retirement dates of 1/1/2016 or later, years of service and age were calculated as of 12/31/2015
PQ	See definition in the Plan document		
BR	Former Placer Sierra retiree retired before 8/1/2007	Yes, company pays 100%	Yes, company pays 100%

Dental

Retiree group

Group	Description	Dental eligibility	Dental rates
A	<ul style="list-style-type: none"> Retiree as of 1/1/1993 of either: <ul style="list-style-type: none"> The former Wells Fargo* The former First Interstate Age 65 and over as of that date 	Eligible under age 65	Active rates
B	<ul style="list-style-type: none"> Retiree as of 1/1/1993 of either: <ul style="list-style-type: none"> The former Wells Fargo* The former First Interstate Under age 65 as of that date 	Eligible under age 65	Active rates
B1	<ul style="list-style-type: none"> Retiree as of 1/1/1993 of either: <ul style="list-style-type: none"> The former Wells Fargo* The former First Interstate Under age 65 as of that date Enrolled in the former Core or Core Excess Plan as of 12/31/2007 	Eligible under age 65	Active rates
C	<ul style="list-style-type: none"> Employee of the former Wells Fargo* on 1/1/1993 <ul style="list-style-type: none"> With 10 years of service as measured from the adjusted service date or corporate hire date, whichever is earlier At least 55 years old Eligible to retire on 1/1/1993 Or Employee of the former First Interstate on 1/1/1997 <ul style="list-style-type: none"> With 10 years of service as measured from the adjusted service date or corporate hire date, whichever is earlier At least 55 years old Eligible to retire on or before 1/1/1997 	Eligible under age 65	<ul style="list-style-type: none"> Active rates if retired before 7/1/1999 Full retiree rates if retired after 7/1/1999
C1	<ul style="list-style-type: none"> Employee of the former Wells Fargo* on 1/1/1993 <ul style="list-style-type: none"> With 10 years of service as measured from the adjusted service date or corporate hire date, whichever is earlier At least 55 years old Eligible to retire on 1/1/1993 Or Employee of the former First Interstate on 1/1/1997 <ul style="list-style-type: none"> With 10 years of service as measured from the adjusted service date or corporate hire date, whichever is earlier At least 55 years old Eligible to retire on or before 1/1/1997 	Eligible under age 65	<ul style="list-style-type: none"> Active rates if retired before 7/1/1999 Full retiree rates if retired after 7/1/1999

* "Former Wells Fargo" refers to employees of the former Wells Fargo & Company and its subsidiaries.

Dental

Retiree group

Group	Description	Dental eligibility	Dental rates
D	<ul style="list-style-type: none"> Employee of the former Wells Fargo* with a hire date before 10/1/1992 but did not meet the retirement criteria on 1/1/1993 Or <ul style="list-style-type: none"> Employee of the former First Interstate with a hire date before 1/1/1992 but did not meet the retirement criteria on 1/1/1997 	Eligible under age 65	<ul style="list-style-type: none"> Active rates if retired before 7/1/1999 Full retiree rates if retired after 7/1/1999
L	Valley National Bank retiree	Eligible	Company pays 100%
AH	Davenport Bank & Trust retiree	Eligible if retired after 10/1987	Reduced retiree rates
AJ	First Illini Bancorporation retiree	Eligible	Reduced retiree rates
AK	First Minnesota retiree	Eligible	Full retiree rates
AM	Ford Bank Group retiree	Eligible	Full retiree rates
AO	Lincoln Financial retiree	Eligible	Full retiree rates minus subsidy; subsidy is a percentage of the total rate set at retirement
AQ	Bank of Montana retiree	Eligible	Full retiree rates
AR	United Bank of Colorado retiree	Eligible	Full retiree rates minus subsidy; subsidy is equal to 100%, 75%, 50%, or 0% of \$19 per month
AZ	Retiree of various Norwest acquired banks <ul style="list-style-type: none"> Fridley State Bank Merchants and Miners Peoples Bank Waterloo 	Eligible	Full retiree rates
BB	First National Bank of Alaska retiree	Eligible under age 65	Active rates
BK	Wells Fargo Financial, retired before 1993	Eligible under age 65	Company pays 100% for dental and vision
BL	Wells Fargo Financial, retired between 1993 and 2005	Eligible under age 65	Company pays 100% for dental and vision
BO	Wisenberg retiree	Eligible	Full retiree rates
BP	Wells Fargo Financial retiree, hired prior to 1/1/2003, but less than 55 years old and with five years of service as of 12/31/2005 or with fewer than 60 points as of 12/31/2004	Eligible under age 65	Full retiree rates
BQ	Wells Fargo Financial retiree, hired prior to 1/1/2003, and as of that date: <ul style="list-style-type: none"> Reached at least 55 years of age, and Had at least five years of credited service as of 12/31/2004 Or <ul style="list-style-type: none"> Had at least 60 points based on age and credited service 	Eligible under age 65	Full retiree rates

* "Former Wells Fargo" refers to employees of the former Wells Fargo & Company and its subsidiaries.

Wachovia* retiree groups before 1/1/2010

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
CBSRO	CenterBank Special Retirement Option, retired from active employment between 5/1/1995 and 12/31/1995	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
CEPR94	Retiree of the former CenterBank before 1/1/1994	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
CFB	Central Fidelity Bank, retired from active employment before 1/1/1993	Yes, subsidy built into rates	Yes, company pays 100%
CLPR95	Retiree of the former Coral Gables Bank before 7/1/1995	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
CS92	CoreStates Bank, retired from active employment between 7/1/1992 and 1/1/1999	Yes, company pays a fixed amount	Yes, subsidy is a fixed amount
CS99CS	CoreStates Bank employee who did not elect a Retirement Medical Allowance and retired from active employment between 1/1/1999 and 12/31/2001	Yes, company pays a fixed amount	Yes, subsidy is a fixed amount
CSPR92	CoreStates Bank, retired from active employment before 7/1/1992	Yes, company pays a fixed amount	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
DB93	Dominion Bank, retired from active employment before 7/1/1993	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
DB930	Dominion Bank, retired from active employment during special window from 5/1/1993 to 7/1/1993 and elected the First Union plan	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan

* If you retired from active employment from a company acquired by the premerger Wachovia Corporation or First Union Corporation, you must have been continuously participating in the plan since the date you first became eligible for benefits. In addition, you must meet the eligibility criteria for your retiree group as identified in Wells Fargo's or its designee's database.

Wachovia* retiree groups before 1/1/2010

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
DDB	<ul style="list-style-type: none"> Retired from active employment between 1/1/1991 and 12/31/2001 <p>And</p> <ul style="list-style-type: none"> Wachovia Corporation retiree before First Union merger <p>Or</p> <ul style="list-style-type: none"> You became an employee of Wachovia Corporation through a corporate merger with Wachovia as an employee of another bank 	Yes, subsidy built into rates	Yes, subsidy is a fixed amount
DDB1	Wachovia Corporation (before First Union merger), retired between 1/1/2001 and 1/1/2002	Yes, subsidy built into rates	Yes, subsidy is a fixed amount
DFPR93	Decatur Federal Bank, retired from active employment before 2/1/1993	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
EV9599	Retiree of EVEREN who retired on or after 7/1/1995 and before 10/1/1999	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
EVPO99	Employee of EVEREN Capital Corporation who retired from active employment on or after 10/1/1999 and before 1/1/2002 and did not elect First Union Retiree benefits	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
EVPR95	Retiree of EVEREN before 7/1/1995	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FAW91	Retiree of the former First American Bankshares between 1/1/1991 and 4/1/1991	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FC7885	Retiree of Fidelcor between 1/1/1978 and 12/31/1985	Yes, retiree pays a fixed amount	Yes, retiree pays a fixed amount

* If you retired from active employment from a company acquired by the premerger Wachovia Corporation or First Union Corporation, you must have been continuously participating in the plan since the date you first became eligible for benefits. In addition, you must meet the eligibility criteria for your retiree group as identified in Wells Fargo's or its designee's database.

Wachovia* retiree groups before 1/1/2010

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
FC8688	Retiree of the former Fidelcor, Inc. on or after 1/1/1986 and before 1/2/1989	Yes, retiree pays a fixed amount	Yes, retiree pays a fixed amount
FFBNJ	Retiree of the former First Fidelity Bank, N.A. New Jersey before 1/1/1989	Yes, company pays 100%	Yes, company pays 100%
FNPR86	Retiree of the former Florida National Bank before 7/1/1986	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FU8692	Retiree of the former Florida National Bank between 7/1/1986 and 2/1/1990	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FU8692	First Union retirees who retired on or after 1/1/1986 and prior to 2/1/1992	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FU8692	Citizens DeKalb Bank, retired from active employment before 4/1/1986	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FU8692	City Commercial Bank of Sarasota, retired from active employment before 4/1/1987	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FU8692	First Bankers Corporation & Subsidiaries, retired from active employment before 5/17/1986	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FU8692	Roswell Bank, retired from active employment before 1/1/1988	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FU8692	Savannah Bank & Trust Co., retired from active employment before 11/1/1986	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FU8692	Southeast Bank, N.A. or Southeast Bank of West Florida, retired from active employment between 2/1/1992 and 4/1/1992	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan

* If you retired from active employment from a company acquired by the premerger Wachovia Corporation or First Union Corporation, you must have been continuously participating in the plan since the date you first became eligible for benefits. In addition, you must meet the eligibility criteria for your retiree group as identified in Wells Fargo's or its designee's database.

Wachovia* retiree groups before 1/1/2010

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
FU8692	Southern Bancorporation and Subsidiaries, retired from active employment before 3/31/1986	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FU9297	First Union retiree who retired between 2/1/1992 and 2/1/1997	Yes, Retirement Medical Allowance	Yes, Retirement Medical Allowance
FUPO97	Wachovia (after First Union merger) retiree who retired on or after 2/1/1997 and before 1/1/2002	Yes, Retirement Medical Allowance	Yes, Retirement Medical Allowance
FUPR86	Atlantic Bancorporation and Subsidiaries, retired before 11/15/1985	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FUPR86	Carolina Finance Company (Piedmont Corp.), retired from active employment before 10/31/1984	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FUPR86	First National Bank of Albemarle, retired from active employment before 12/31/1981	Yes, company pays 100%	Yes, company pays 100%
FUPR86	First National Bank of Catawba County, retired from active employment before 11/1/1981	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FUPR86	First Railroad & Banking Company of Georgia, retired from active employment before 11/1/1986	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FUPR86	First Union, retired from active employment before 2/1/1992	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FUPR86	Northwestern Financial Corporation and Subsidiaries, retired from active employment before 11/30/1985	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan

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Wachovia* retiree groups before 1/1/2010

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
FUPR86	Piedmont Corporation and Subsidiaries, retired from active employment before 12/31/1983	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FY92H, FY92L, FYUSHC, FYKEY	Retiree of the former First Fidelity Bank, N.A. before 7/1/1992	Yes, retiree pays a fixed amount	Yes, retiree pays a fixed amount
FY92N	First Fidelity Bank, retired from active employment between 7/1/1992 and 1/1/1996 and did not meet the Rule of 75	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FY92Y	First Fidelity Bank employee who did not elect a Retirement Medical Allowance and retired from active employment between 1/2/1996 and 9/30/1998	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
FY92Y	First Fidelity Bank, retired from active employment between 7/1/1992 and 1/1/1996, and whose age plus service is greater than or equal to 75	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
GCPR94	Retiree of the former Center Bank between 1994 and 1996	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
GCPR94	Retiree of the former Great Country before 1/1/1994	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
GFPR93	Retiree of the former Georgia Federal Bank before 6/12/1993	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
GRWICH	Retiree of the former Greenwich Federal Savings Bank before 1/1/1994	Yes, company pays 100%	Yes, company pays 100%
GSPR95	Germantown Savings Bank, retired from active employment before 1/1/1995	None	None

* If you retired from active employment from a company acquired by the premerger Wachovia Corporation or First Union Corporation, you must have been continuously participating in the plan since the date you first became eligible for benefits. In addition, you must meet the eligibility criteria for your retiree group as identified in Wells Fargo's or its designee's database.

Wachovia* retiree groups before 1/1/2010

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
GSPR95	Independence Bancorp Incorporated, retired from active employment before 1/1/1995	None	None
HSPR95	Home Federal Savings, retired from active employment before 1/1/1995	Yes, company pays 100%	Yes, company pays 100%
KSPR96	Keystone Investments, retired from active employment before 12/12/1996	Yes, company pays a fixed amount	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
MD	Meridian Bank, retired from active employment before 1/1/1997	Yes, subsidy built into rates	Yes, subsidy is a fixed amount
MRC107 and MS8488	Retiree of the former Merchants Bancorp between 10/1/1984 and 12/31/1988	None	Yes, company pays 100%
MS4171	Money Store, retired from active employment during the transition window between 4/1/1999 and 7/1/1999	Yes, subsidy built into rates or has Retirement Medical Allowance	Yes, subsidy built into rates or has Retirement Medical Allowance
MSPR84	Merchants Bank, retired from active employment before 10/1/1984	Yes, company pays 100%	Yes, company pays 100%
NEBR	NE Bankcorp Balkham and Randall retirees who retired before 1/1/1994	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
NEPR94	Retiree of the former Northeast Bancorp before 1/1/1994	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
NGS	Central Fidelity Bank, retired from active employment between 1/1/1993 and 1/1/1998	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
NGS	First Atlanta Bank, retired from active employment before 1/1/1989	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan

* If you retired from active employment from a company acquired by the premerger Wachovia Corporation or First Union Corporation, you must have been continuously participating in the plan since the date you first became eligible for benefits. In addition, you must meet the eligibility criteria for your retiree group as identified in Wells Fargo's or its designee's database.

Wachovia* retiree groups before 1/1/2010

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
NGS	IJL, retired before 1/1/2000	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
NGS	Retiree of the former South Carolina Federal before 1/1/1992	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
NGS	Wachovia Corporation (before First Union merger), retired from North Carolina and Georgia before 1/1/1991 (including Bank of Canton)	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
P<8/85	Prudential Securities Inc., retired before 8/1/1985	Yes, company pays 100% for retiree only	Yes, company pays 100% for retiree only
P85-89	Prudential Securities Inc., retired between 8/1/1985 and 8/30/1989	Yes, subsidy built into rates	Yes, subsidy is a fixed amount
P89-91	Prudential Securities Inc., retired between 9/1/1989 and 12/31/1991	Yes, subsidy built into rates	Yes, subsidy is a fixed amount
P93-05	Prudential Securities Inc., retired from active employment before 1/1/2004 and your age plus years of service equal 75 (as determined by the plan administrator)	Yes, Prudential Securities Inc. Retirement Medical Allowance	Yes, Prudential Securities Inc. Retirement Medical Allowance
PSI92	Prudential Securities Inc., retired between 1/1/1992 and 12/31/1992	Yes, subsidy built into rates	Yes, subsidy is a fixed amount
PWPR94	Retiree of the former Peoples Westchester Savings Bank before 1/1/1994	None	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
SCPR93	South Carolina Federal, retired from active employment before 2/1/1993	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
SEN83	Southeast National Bank, retired from active employment before 1/1/1983	Yes, company pays 100%	Yes, company pays 100%

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Wachovia* retiree groups before 1/1/2010

Retiree group

Group	Description	Medical subsidy, pre-Medicare eligible	Medical subsidy, eligible for Medicare
SNPR98	Signet Bank, retired from active employment before 1/1/1998 or retired between 1/1/1998 and 10/1/1998 and elected Signet benefits	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
ST50	South Trust, retired during the window between 1/1/2005 and 1/1/2007 and elected South Trust benefits	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
ST51	South Trust, retired from active employment before 2/1/2005	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan
VBR94	Retiree of Village Bank before 1/1/1994	Yes, subsidy built into rates	Yes, subsidy is a percentage of the cost of the UHC Group Medicare Advantage Plan

* If you retired from active employment from a company acquired by the premerger Wachovia Corporation or First Union Corporation, you must have been continuously participating in the plan since the date you first became eligible for benefits. In addition, you must meet the eligibility criteria for your retiree group as identified in Wells Fargo's or its designee's database.

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Appendix E: Continuing Coverage Under COBRA

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Federal law requires that the Wells Fargo retiree group health plans give qualified beneficiaries the opportunity to continue their health care coverage when there is a qualifying event that causes a loss of coverage under the Wells Fargo retiree group health plan. As used in the “COBRA general notice” section below and in the [“COBRA administrative information”](#) section starting on page E-4, the term “Wells Fargo retiree group health plan” or “group health plan” means the medical (including the prescription drug benefit), dental, and vision benefit options under the Wells Fargo & Company Retiree Plan (the Plan or Retiree Plan). Depending on the type of qualifying event, qualified beneficiaries can include a Wells Fargo retiree’s covered spouse or domestic partner, and covered dependent children. In this section, Wells Fargo retirees 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 COBRA Administrator. The COBRA Administrator is BenefitConnect™ | COBRA.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees, or Medicare if you are Medicare Eligible.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of certain life events. These events are called “qualifying events.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You (only in certain limited situations), your covered spouse or covered domestic partner, and your covered dependent children could become qualified beneficiaries if

coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

A covered spouse or domestic partner of a retiree will become a qualified beneficiary if coverage is lost because of one of the following qualifying events:

- The covered retiree and covered spouse divorce or legally separate, or the covered employee and covered domestic partner terminate their domestic partnership or civil union.

A covered dependent child will become a qualified beneficiary if coverage is lost because of one of the following qualifying events:

- The covered retiree and spouse divorce or legally separate (applies to the Wells Fargo retiree’s covered stepchildren only) or the covered retiree and domestic partner terminate their domestic partnership or civil union (for covered children of the domestic partner only).
- The child stops being eligible for coverage under the Plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Wells Fargo & Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse or a domestic partner, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. The employer must notify the COBRA Administrator of the following qualifying event: commencement of a proceeding in bankruptcy with respect to the employer.

For all other qualifying events (divorce or legal separation of the retiree and a spouse, termination of a domestic partnership or civil union of the retiree and partner, or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Wells Fargo Retirement Service Center within 60 days after the date coverage would end by calling 1-877-HRWELLS (1-877-479-3557), option 1.

How is COBRA continuation coverage provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. Certain qualifying events may permit a beneficiary to receive a maximum of 36 months of coverage.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP)¹, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period² to sign up for Medicare Part A or B, beginning on the earlier of the following:

- The month after your employment ends
- The month after group health plan coverage, based on current employment, ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information about Medicare, visit <https://www.medicare.gov/medicare-and-you>.

1. <https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program>.
2. <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator: BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). Representatives are available from Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time. You may also access <https://cobra.ehr.com>.

For more information about your rights under the Employee Retirement Income Security Act (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 the Wells Fargo Retirement Service Center know about any changes in addresses of family members by calling 1-877-HRWELLS (1-877-479-3557), option 1. Once enrolled in COBRA, let BenefitConnect™ | COBRA know about any changes in addresses of family members (see contact information below). You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Plan contact information

For more information about COBRA continuation coverage and the Wells Fargo & Company Retiree Plan:

- Visit <https://cobra.ehr.com>
- Call the COBRA Administrator, BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only)
- Send a written request to:
BenefitConnect | COBRA
DEPT: COBRAUS
PO Box 981914
El Paso, TX 79998

Important information about payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election. If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of each month. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for periodic payments

Although periodic payments are due on the dates stated above, you'll be given a grace period of 30 days after the first day of the month to make each periodic payment.

COBRA administrative information

General information

COBRA continuation coverage is the same coverage that the Wells Fargo Retiree Plan gives 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 the Wells Fargo Retiree Plan as other plan participants, including Annual Benefits Enrollment.

Coverage and eligibility rights

Plan coverage may be continued through COBRA continuation coverage only for those individuals who are “qualified beneficiaries.” Qualified beneficiaries include any of the following who were covered under the plan on the day immediately preceding the qualifying event (the specific primary qualifying events identified in the table below that cause a loss of coverage):

- The covered retiree (only in the event of a bankruptcy)
- The covered spouse or domestic partner
- The covered dependent child

“Coverage and eligibility rights” information is continued at the top of the next column.

Primary qualifying events

The following qualifying events give qualified beneficiaries the opportunity to continue their health care coverage when the event causes a loss of coverage:

Covered retiree	Covered spouse or domestic partner	Covered dependent children
<ul style="list-style-type: none">• Wells Fargo & Company bankruptcy	<ul style="list-style-type: none">• The covered retiree and covered spouse divorce or legally separate, or the covered retiree and covered domestic partner terminate their domestic partnership or civil union• Wells Fargo & Company bankruptcy	<ul style="list-style-type: none">• The covered retiree and spouse divorce or legally separate (for the retiree’s covered stepchildren only), or the covered retiree and domestic partner terminate their domestic partnership or civil union (for covered children of domestic partner only)• Loss of dependent status• Wells Fargo & Company bankruptcy

Your notification responsibilities — primary qualifying events

Wells Fargo will have knowledge of a Wells Fargo & Company bankruptcy. However, you, your covered spouse or domestic partner, or covered dependent child, must call the Wells Fargo Retirement Service Center at 1-877-HRWELLS (1-877-479-3557), option 1 when one of the following events occurs:

- A divorce, legal separation, or termination of domestic partnership or civil union.

In the event of divorce, notify the Wells Fargo Retirement 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.

Each qualified beneficiary has the right to elect coverage regardless of what the retiree or other covered dependents choose.

New dependent eligibility and rights

Newly eligible dependents may be added to coverage after the initial COBRA qualifying event, provided that they meet the eligibility requirements and are enrolled within 60 days of becoming eligible. However, except for the covered retiree’s newborn or newly adopted children, dependents added after the qualifying event are not qualified beneficiaries and do not have separate and independent COBRA rights. 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 (1-877-292-6272) (858-314-5108 International only) or online at <https://cobra.ehr.com> within 60 days of the dependent becoming eligible. Most changes in coverage are effective the first of the month following the date of the event or the date you notify BenefitConnect™ | COBRA, whichever is later. **Note:** The timely medical plan enrollment of your dependent gained through birth, adoption, or placement for adoption will be made retroactively to the date of birth, adoption, or placement for adoption.

Notice must be provided to the Wells Fargo Retirement Service Center within 60 days of the date coverage would be lost due to one of the qualifying events. If you, your covered spouse or domestic partner, or your covered dependent child, wait longer than 60 days to notify the Wells Fargo Retirement Service Center of the qualifying event, COBRA continuation rights may not apply.

When the Wells Fargo Retirement Service Center is notified that one of these events has occurred and the mailing address of the qualified beneficiary has been confirmed, the COBRA administrator will notify the appropriate parties of their COBRA continuation coverage rights. **Note:** A notice to your spouse or domestic partner is treated as notice to any covered dependents who reside with the spouse or domestic partner.

Length of COBRA continuation coverage

The maximum length of COBRA continuation coverage for qualified beneficiaries under each qualifying event is as follows:

Qualifying event	Maximum extension and cost
A covered dependent child stops being eligible for coverage under the Plan as a “dependent child.”	36 months, full cost ^{1,2}
The covered retiree and spouse divorce or legally separate, or the covered retiree and domestic partner terminate their domestic partnership or civil union. ³	36 months, full cost ^{1,2}
Wells Fargo & Company bankruptcy.	36 months, full cost ^{1,2}

1. Full cost is the total contribution due, including what was previously paid by you and Wells Fargo, and an additional 2%.

2. Coverage may terminate before the end of the maximum extension as described in the “[End of COBRA continuation coverage](#)” section on page E-8.

3. 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 covered spouse or covered 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-4), 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 the domestic partnership.

The “Length of COBRA continuation coverage” table above shows the maximum period of COBRA continuation coverage available to qualified beneficiaries. The length of extended coverage under COBRA depends upon the qualifying event triggering eligibility, as illustrated in the table above. 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-8.

Electing COBRA continuation coverage

To elect COBRA continuation coverage, you or your dependent must access <https://cobra.ehr.com> or call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) to make the 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, 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.

COBRA election period

Qualified beneficiaries have until the later of the following time periods to elect COBRA continuation coverage:

- 60 days from the date of the COBRA Election Notice
- 60 days from the date coverage terminates

The specific COBRA enrollment deadline will be communicated in the COBRA Election Notice.

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.

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 coverage will receive a letter confirming your COBRA enrollment after COBRA enrollment elections have been made, either after initial enrollment under COBRA or during Annual Benefits Enrollment. You may also confirm your COBRA enrollment elections online at <https://cobra.ehr.com>. If the enrollment information does not match the elections made, call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). If you are outside of the 60-day enrollment period or the Annual Benefits Enrollment change period, no corrections can be made to COBRA benefit enrollment elections.

Cost of COBRA continuation coverage

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 retiree contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. The additional 2% 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 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 the qualified beneficiary (your covered dependent). Shortly after COBRA coverage has been elected, a packet of COBRA payment coupons, with a coupon for each monthly payment due in the current plan year, will be sent that should be used to submit payments. However, after the first payment has been made, COBRA continuation coverage may be paid through one of the following options:

- Pay by one-time ACH payment. To make payments by one-time ACH payment, navigate to <https://cobra.ehr.com> or call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). You may use a one-time ACH payment for your first payment and any subsequent payments. If payment is made by one-time ACH payment, your payment is considered to be made on the date that the payment is submitted.
- Enroll in the Auto Pay program (direct debit payment) option following instructions in the COBRA Election Notice. You may enroll in Auto Pay online at <https://cobra.ehr.com> or by calling BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).
- Pay by check, cashier's check, or money order via U.S. mail with the applicable monthly coupon from the packet of COBRA payment coupons sent after electing COBRA continuation coverage (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 COBRA continuation coverage is first elected. 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. The first payment for COBRA continuation coverage must be made by one-time ACH payment, check, cashier's check, or money order no later than 45 days after the date the COBRA continuation coverage election is made. The payment due date will be indicated on the applicable COBRA payment coupon.

Payment should be mailed to the address indicated in the COBRA Election Notice or on the COBRA payment coupons received following the applicable COBRA continuation coverage election or any subsequent coverage change. When making payment, include the applicable 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 the qualified beneficiaries (your dependents) are timely enrolled with COBRA and make payment within 45 days of the COBRA election date.

If a COBRA payment is not made on time, COBRA continuation coverage rights will be lost under the Wells Fargo Retiree Plan.

Important notes

- You or your enrolled dependents are responsible for making sure that the amount of the first COBRA payment is correct. If there are any questions concerning the payment due, contact BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).
- The first payment for COBRA continuation coverage is due within 45 days from the date the qualified beneficiary made his or her COBRA election even if the packet of COBRA payment coupons has not been received. Include the unique Customer ID (found on the COBRA Election Notice) with the payment and send to the address noted on your COBRA payment coupon.
- A packet of monthly COBRA payment coupons, with a coupon for each monthly payment due in the current plan year, is generally sent within two weeks following the date COBRA continuation coverage is elected. If the packet of COBRA payment coupons is not received by this date, call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).
- Mail the required COBRA payment by regular U.S. mail with the applicable monthly COBRA payment coupon to the address noted on your payment coupon. If you need to send your payment by overnight delivery, call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).
- Pay by one-time ACH payment.
To make payments by one-time ACH payment, navigate to <https://cobra.ehr.com>, or call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). If payment is made by one-time ACH payment, your payment is considered to be made on the date that the payment is submitted.
- Failure to submit the required COBRA payment as described 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 the first COBRA payment is made, payments are due 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 COBRA continuation coverage is elected. If you have not received your packet of COBRA payment coupons within this time period, call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).

The qualified beneficiary will not be billed for COBRA continuation coverage each month. Each COBRA participant is responsible for making monthly payments by the due date.

To have monthly COBRA payments deducted directly from a bank account, one may choose to enroll in the Auto Pay program. Enroll online at <https://cobra.ehr.com> or call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).

After enrolling in the Auto Pay program, payment for monthly COBRA premiums will be deducted from the designated bank account on the first business day of the month. The total amount deducted will include the payment owed for the current month, as well as any outstanding balance owed in prior months.

If you have not enrolled in the Auto Pay program, subsequent payments must be sent to BenefitConnect™ | COBRA by a one-time ACH payment or regular U.S. mail and postmarked by the due date as indicated on the applicable monthly COBRA payment coupon. If you do not have a COBRA payment coupon, call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) to obtain the address to submit payment. You may also call BenefitConnect™ | COBRA to obtain an address to submit your payment by overnight delivery.

All COBRA payments are due by the first of the month for which you want coverage.

If the COBRA payment is late, you have a 30-day grace period to make full payment as described in the “Grace periods for monthly payments” section starting on this page. This grace period does not apply to the first payment due.

Payments made or postmarked after the due date as indicated on the applicable monthly COBRA payment coupon will be deposited before a determination is made as to whether any such payment is timely made. Late payments received after the grace period will be refunded and will not extend 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 a COBRA payment is not made on time, COBRA continuation coverage rights will be lost under the Wells Fargo Retiree Plan.

Grace periods for monthly payments

Although monthly payments must be made or postmarked by the due date indicated on the applicable monthly COBRA payment coupon, you will be given a 30-day grace period after this date to make each monthly payment. BenefitConnect™ | COBRA will mail you a COBRA premium reminder letter if you have an outstanding balance due after the applicable monthly due date has passed. This letter will indicate the outstanding balance due and the date payment must be made or postmarked in order for coverage to continue. The due date indicated in this letter will include the 30-day grace period. You are responsible for ensuring all payments are made and postmarked by the due date or by the end of the grace period.

COBRA continuation coverage will be provided for each month, as long as payment for that month is made or postmarked before the end of the grace period for that specific payment. It is important to note that the grace period does not apply to the first payment due. In addition, if the premium you send is insufficient by an insignificant amount (the lesser of 10% or \$50), you will be permitted to cure that insufficiency within the next 30 days and not lose COBRA coverage.

If the required monthly payment is not made or postmarked by the due date as indicated on the applicable monthly COBRA payment coupon or within the grace period, the enrolled qualified beneficiary will lose all rights to COBRA continuation coverage under the Wells Fargo Retiree Plan.

For example, the COBRA payment for coverage for the month of January is due and must be made or postmarked by January 1. However, if the payment is missed or delayed, the delinquent payment must be made or postmarked on or before January 31 to be considered timely made for the January coverage. If the payment is made or postmarked February 1 or after, it will not be applied to the 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 and will not extend COBRA continuation coverage. Depositing of payments should not be construed as acceptance of payment in full.

Please remember that COBRA payments should be submitted with the applicable monthly COBRA payment coupon. Follow the instructions for submitting your payment; the information is found in your packet of monthly COBRA payment coupons. However, if you do not have the applicable COBRA payment coupon, call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) to obtain the address to submit payment. You may also call BenefitConnect™ | COBRA to obtain an address to submit your payment by overnight delivery.

Changing COBRA continuation coverage

Whenever the status of a dependent (the COBRA participant) changes, you or your dependent must notify BenefitConnect™ | COBRA of the change within 60 days. COBRA continuation coverage may be modified based on plan rules if a Qualified Event occurs (for example, birth, marriage, legal separation, divorce, termination of a domestic partnership, or change in dependent eligibility). Refer to “[Chapter 1: Eligibility, Enrollment, and More](#)” in this *Retiree Benefits Book* for a complete list of Qualified Events. Premiums may be adjusted for coverage changes.

Adding a dependent to COBRA continuation coverage

Although eligible dependents may be added if a Qualified Event occurs, these dependents will generally not be qualified beneficiaries. If a Qualified Event occurs permitting a newly eligible dependent to be added to existing COBRA continuation coverage, notify BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at <https://cobra.ehr.com> within 60 days of the Qualified Event.

Note: To add a child born to the covered participant or placed for adoption with the covered participant during the COBRA continuation period, notify BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at <https://cobra.ehr.com> within 60 days of the date of birth or placement. If enrolled within 60 days of the date 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 COBRA continuation coverage or removing a dependent from coverage

Certain events result in your dependent (the COBRA participant) becoming ineligible for coverage before the maximum COBRA period is reached and require discontinuing or making a change to the COBRA continuation coverage election. Notify BenefitConnect™ | COBRA immediately by calling 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at <https://cobra.ehr.com> if the following event occurs:

- **Obtaining 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.

Premiums or contributions will continue to be taken and processed until you notify and provide any required documentation to BenefitConnect™ | COBRA. Claims incurred after the end of the month in which coverage ends will be denied. If required documentation is not received by BenefitConnect™ | COBRA, your dependent (the COBRA participant) will be provided notice, after which coverage will terminate as of the date of loss of eligibility.

Voluntarily dropping COBRA continuation coverage

A COBRA participant may drop COBRA continuation coverage for himself or herself or for any covered dependents at any time by calling BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only).

Changes made to 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 the previous election or coverage level until the effective date of the change in coverage. For example, you are enrolled with You + Child COBRA medical coverage. You call BenefitConnect™ | COBRA on May 5 and request to drop your child from your COBRA medical coverage.

- Your child will be dropped from your COBRA medical coverage effective June 1.
- You must pay the You + Child 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 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 your dependent has other group insurance or Medicare and elects COBRA continuation coverage under the Wells Fargo Retiree Plan, 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 the Summary Plan Descriptions from both plans. You or your dependent must notify the claims administrator for the plan or plans in which your dependent is enrolled if he or she has other coverage. Coordination of benefits information for the Wells Fargo-sponsored health plans is found in "[Chapter 1: Eligibility, Enrollment, and More](#)" in this *Retiree Benefits Book*.

End of COBRA continuation coverage

If your dependents choose COBRA continuation coverage, it may be continued for the period of time indicated in the "[Length of COBRA continuation coverage](#)" section on page E-5. Whenever the status of your dependent (the COBRA participant) changes, you or your dependent must notify BenefitConnect™ | COBRA of the change within 60 days. (See the "[Changing COBRA continuation coverage](#)" section starting on page E-7 for more information.)

However, coverage will end before the maximum extension date if any of the following situations occur:

- **Any required premium or contribution is not paid in full.** Coverage will be terminated retroactively to the end of the month for which full payment was made.
- **COBRA payments are not made or postmarked as of the due date and exceed the 30-day grace period.** Coverage will be terminated retroactively to the end of the month for which full payment was made.
- **Wells Fargo no longer provides group medical, dental, or vision coverage.** Coverage will terminate on the date the applicable coverage is no longer offered.
- **Obtaining 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 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 or your dependent needs additional information, access <https://cobra.ehr.com> or call BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only). Representatives are available from Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time.

For more information about health insurance options available through a Health Insurance Marketplace, visit [healthcare.gov](https://www.healthcare.gov).

Keep your Plan informed of address changes

To protect your and your family's rights, you should keep BenefitConnect™ | COBRA informed of any changes in your address and the addresses of family members by calling 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only) or online at <https://cobra.ehr.com>. You should also keep a copy for your records of any correspondence with BenefitConnect™ | COBRA.

Plan contact information

For more information about COBRA continuation coverage and the Wells Fargo & Company Retiree Plan:

- Visit <https://cobra.ehr.com>
- Call the COBRA Administrator, BenefitConnect™ | COBRA at 1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only)
- Send a written request to:
BenefitConnect | COBRA
DEPT: COBRAUS
PO Box 981914
El Paso, TX 79998

Notice regarding state continuation of coverage

If you are covered under an insured medical option, you may be entitled to additional continuation of coverage (provided by the insurance carrier in accordance with state law). Contact the insurance carrier that insures your option for more information. If you are not sure whether you are covered under an insured option, you can determine this by looking up your option in this *Retiree 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.

