WELLS FARGO

2024 Summary of Material Modifications Benefits Book Chapter 2: Medical Plans

This notice is for informational purposes only to let you know that the "Fertility solutions" section in "Chapter 2: Medical Plans" of the *Benefits Book* effective January 1, 2024, has been updated. You may or may not expect to receive the services described, but we are required to provide this update for your awareness. **No action is required.**

The Wells Fargo & Company Health Plan (Health Plan) includes the Copay Plan with HRA, the Local Copay Plan with HRA, the HSA Plan, and the Flex HDHP Plan. The Summary Plan Description (SPD) for these medical plan options is stated in the *Benefits Book*. The SPD gives you information about what is and is not covered.

This document is a Summary of Material Modifications (SMM) effective on January 1, 2024 and corrects a printing error in the applicable portion of the SPD stated in "Chapter 2: Medical Plans" in the *Benefits Book*, effective January 1, 2024.

The "Covered" and "Not covered" column headings have been added and the section titled "Fertility solutions" starting on page 2-68 of "Chapter 2: Medical Plans" is replaced in its entirety with the information on the following pages.

Fertility solutions

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

Covered	Not covered
Fertility solutions benefits listed below are provided only to a covered employee or dependent, not to a surrogate: • Artificial insemination (AI). • Intrauterine insemination. • In vitro fertilization (fresh IVF cycle). • Embryo adoption preparation and transfer. • Frozen embryo transfer (FET) cycle, including the associated cryopreservation and storage of embryos. Long-term storage costs (anything longer than 12 months) are the responsibility of the member. • Gamete intrafallopian transfer (GIFT). • Zygote intrafallopian tube transfer (ZIFT). • Intracytoplasmic sperm injection (ICSI). • Ovulation induction and controlled ovarian stimulation. • Preimplantation genetic diagnosis (PGD) is covered for the diagnosis of known genetic disorders only (for example, cystic fibrosis). • Preimplantation genetic screening (PGS). • Testicular sperm aspiration (TESA). • Microsurgical epididymal sperm aspiration (MESA). • Electroejaculation (EEJ). • Surgical procedures: - Laparoscopy - Lysis of adhesions - Tubotubal anastomosis following a nonvoluntary sterilization - Fimbrioplasty - Salpingostomy - Transcervical catheterization - Strassman metroplasty • Donor coverage. The plan will cover associated donor medical expenses only when the donor is a covered member (of a self-insured option of the Wells Fargo Health Plan), including preparation of oocyte or sperm. A covered female member's ovary stimulation and retrieval of eggs are covered when a member is using a surrogate (host uterus). The implantation of eggs, oocytes, embryo, or donor sperm into a host uterus is not covered. Male member retrieval of sperm is covered. The plan will not pay for donor charges associated with compensation or administrative services. • Fertility preservation. The plan will cover fertility preservation for a covered member when diagnosis of cancer is present, and treatment is likely to produce infertility or sterility. Coverage is limited to collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of eggs, oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are the responsibility of the member. • Infertility treatment following the successful reversal of voluntary sterilization (tubal reversal/reanastomosis, vasectomy reversal/vasovasostomy or vasoepididymostomy). • As new services and treatments become available, they will be considered for coverage based on the claims administrator's policy guidelines.	• Charges related to a surrogate or gestational carrier on your behalf, including any donor, insemination, transfer, or implantation processes. • Reversal of voluntary sterilization and any related charges. • Treatment of infertility/fertility after unsuccessful reversal of sterilization and any related charges. • Fees or payment associated with embryo adoption. • Fees or payment to a donor associated with compensation or administrative services for sperm or oocyte donations. • Fees for maintenance or storage of sperm or oocyte, except as otherwise noted. • Fees for maintenance or storage of frozen embryos beyond 12 months. • Medications for anyone not enrolled in the plan, including a donor or surrogate. • Services and prescription drugs for or related to gender selection services. • Services exceeding the lifetime maximum for this benefit. • Social cryopreservation to delay pregnancy when a diagnosis of cancer is not present. • Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation). • Also, see the "Exclusions" section starting on page 2-103.

Cost sharing:

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

Other important information

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

Fertility solutions benefits are limited to a lifetime maximum benefit paid by the medical plan of $25,000 in-network and out-of-network medical services combined; services from an out-of-network provider are only covered for individuals with Out of Area coverage under the HSA Plan and the Copay Plan with HRA.

There is a separate lifetime maximum benefit of $10,000 for related prescription drugs, in-network and out-of-network combined. See the "Prescription drug benefit" section starting on page 2-112 for more information on prescription drugs, coverage, and pre-service authorization requirements.

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

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