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UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

SERGIO NAVARRO, THERESA GAMAGE, DAYLE BULLA, and JANE KINSELLA, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans, Plaintiffs, v. WELLS FARGO & COMPANY, MICHAEL BRANCA, MARK HICKMAN, DREW WINELAND, DAVID GALLOREESE, BEI LING, and DOES 1-20, Defendants.	No. 0:24-cv-03043-KMM-DTS

DECLARATION OF CLARE VERPLANK IN SUPPORT OF DEFENDANT WELLS FARGO & COMPANY'S MOTION TO DISMISS THE CLASS ACTION COMPLAINT

I, Clare Verplank, declare as follows:

1. I am currently employed as Benefits Director at Wells Fargo & Company ("Wells Fargo") and, in this role, I am involved with the administration of the Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents) (the "Plan").

2. I provide this declaration in support of Defendant Wells Fargo & Company's[1] Motion to Dismiss the Class Action Complaint.

3. This Declaration is based upon my personal knowledge, records generated and maintained by Wells Fargo in the ordinary course of business, and publicly-available information, and, if called upon to testify, I could and would testify competently thereto.

4. Attached hereto as **Exhibit A** is a true and correct copy of the Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents), as amended and restated effective January 1, 2024 (the "Plan Document"). The relevant terms of the Plan Document have been the same at all relevant times.

5. Attached hereto as **Exhibit B** is a true and correct copy of excerpts from the Plan's 2024 Benefits Book (the "Summary Plan Description" or "SPD"). A complete copy of the 2024 SPD is publicly-available at https://teamworks.wellsfargo.com/pdf/Benefits_Book.pdf. The relevant terms of the SPD have been the same at all relevant times.

6. I understand that the Class Action Complaint in this matter includes allegations regarding the purported costs of certain prescription drugs to the Plan and Plan participants. The Plan's prescription drug website is publicly-available at https://www.express-scripts.com/frontend/open-enrollment/wellsfargo. At the initial page

[1] The individually named Defendants were voluntarily dismissed from the case pursuant to a joint stipulation. (ECF No. 27.)

of the website, anyone can input an applicable Plan benefit option (e.g., HSA Plan, Copay Plan with HRA) and whether coverage is for an individual or includes dependents. Once that information is entered, anyone may select the "Price a Medication" option and enter prescription drug and other required information to receive an estimate of the cost of a prescription drug to the Plan and to a hypothetical Plan participant, *see* https://www.express-scripts.com/frontend/open-enrollment/wellsfargo/plans/5b870186224e770053efd7ef/apps/medication#/. Attached hereto as **Exhibit C** is a screenshot from the Plan's prescription drug website.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

Executed on September 26, 2024

Signed by:
Clare Verplank
53B11A0C1980414...

Clare Verplank

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

SERGIO NAVARRO, THERESA GAMAGE, DAYLE BULLA, and JANE KINSELLA, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans, Plaintiffs, v. WELLS FARGO & COMPANY, MICHAEL BRANCA, MARK HICKMAN, DREW WINELAND, DAVID GALLOREESE, BEI LING, and DOES 1-20, Defendants.	No. 0:24-cv-03043-KMM-DTS

INDEX OF EXHIBITS TO DECLARATION OF CLARE VERPLANK IN SUPPORT OF DEFENDANT WELLS FARGO & COMPANY'S MOTION TO DISMISS THE CLASS ACTION COMPLAINT

EXHIBIT	DESCRIPTION
A	Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents) (as amended and restated effective January 1, 2024)
B	Benefits Book – A Guide to Your Wells Fargo Benefits (Effective January 1, 2024) (Excerpts)
C	Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents) – Screenshot from Prescription Drug Website

EXHIBIT A

WELLS FARGO & COMPANY HEALTH PLAN
(FOR ELIGIBLE ACTIVE EMPLOYEES AND THEIR DEPENDENTS)

(As Amended and Restated Effective January 1, 2024)

Table of Contents

WELLS FARGO & COMPANY HEALTH PLAN
(FOR ELIGIBLE ACTIVE EMPLOYEES AND THEIR DEPENDENTS)

As Amended and Restated Effective January 1, 2024

SECTION 1
INTRODUCTION

The Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents) is hereby amended and restated effective January 1, 2024 (the "Plan"). This Plan Statement, together with the applicable Insurance Policies and Summary Plan Descriptions, as they may be amended from time to time, shall constitute the written plan document for the Plan for purposes of ERISA. Capitalized terms as used in this Plan Statement shall have the meanings defined in this Plan Statement.

1.1 History of the Plan.

Effective January 1, 2011, the Plan was established to provide group health plan benefits for Employees and their Dependents.

1.2 Rules of Interpretation. When interpreting the provisions of this Plan Statement, the following rules of interpretation shall apply.

(a) An individual shall be considered to have attained a given age on the individual's birthday for that age (and not on the day before).

(b) The birthday of any individual born on a February 29 shall be deemed to be February 28 in any year that is not a leap year.

(c) Whenever appropriate, words used herein in the singular may be read in the plural, or words used herein in the plural may be read in the singular; the masculine may include the feminine; and the words "hereof," "herein" or "hereunder" or other similar compounds of the word "here" shall mean and refer to the entire Plan Statement and not to any particular paragraph or section of the Plan Statement unless the context clearly indicates to the contrary.

(d) The titles given to the various sections of the Plan Statement are inserted for convenience of reference only and are not part of the Plan Statement, and they shall not be considered in determining the purpose, meaning or intent of any provision hereof.

(e) Any reference in the Plan Statement to a statute or regulation shall be considered also to mean and refer to any subsequent amendment or replacement of that statute or regulation.

(f) In the event of any inconsistency or conflict in the provisions of this Plan Statement, the Summary Plan Descriptions, and/or an Insurance Policy, the order of precedence shall be as follows:

(1) If there are any inconsistencies or conflicts between an Insurance Policy and this Plan Statement with respect to eligibility for coverage, the Plan Statement shall govern.

(2) If there are any inconsistencies or conflicts between an Insurance Policy and Summary Plan Description with respect to eligibility for coverage, the Summary Plan Description shall govern.
(3) If there are any inconsistencies or conflicts between an Insurance Policy and this Plan Statement with respect to benefits, the Insurance Policy shall govern.
(4) If there are any inconsistencies or conflicts between an Insurance Policy and Summary Plan Description with respect to benefits, the Insurance Policy shall govern.
(5) If there are any inconsistencies or conflicts between a Summary Plan Description and this Plan Statement, the Plan Statement shall govern.

(g) To the extent any provision of this Plan Statement is determined to be inconsistent with section 105 of the Code, when applicable, such provision is modified such that it is consistent with section 105 of the Code, and if such provision cannot be so modified, then the provision is void.

(h) Except to the extent that federal law is controlling, this Plan Statement shall be construed and enforced in accordance with the laws of the State of Minnesota.

SECTION 2
DEFINITIONS

When the following capitalized terms are used in this Plan Statement they shall have the following meanings:

2.1 Affiliate. An "Affiliate" means any trade or business entity under Common Control with a Participating Employer or under Common Control with a Predecessor Employer while it is such.

2.2 Benefits Eligible Rehired Retiree. A "Benefits Eligible Rehired Retiree" is any Employee who on the day immediately prior to their first day of employment with the Employer or any of its Affiliates is (1) a participant in the Wells Fargo & Company Retiree Plan ("Retiree Plan"), and (2) enrolled in retiree medical, dental, and/or vision coverage under the Retiree Plan. For purposes of this provision, medical coverage under the Retiree Plan includes Employer-sponsored Medigap coverage, Employer-sponsored Medicare Advantage Plan coverage, participation in the Retirement Medical Allowance Account ("RMAA") and participation in the Prudential Securities Inc. Retirement Medical Allowance ("PSI-RMA").

2.3 Benefit Option(s). The "Benefit Option" or "Benefit Options" are the various benefit options provided under the Plan. The Benefit Options include Self-Insured Health Benefit Options and Insured Health Benefit Options. As of the effective date of this Plan Statement, the Benefit Options available under the Plan are identified in Exhibit A. The Benefit Options listed in Exhibit A, are incorporated into and made a part of this Plan Statement. The Benefit Options shall also include benefit options provided under the Plan in prior Plan Years and no longer offered, but only to the extent benefit claims incurred under such Benefit Options during such prior Plan Years are processed as run-out claims.

2.4 CHIP. "CHIP" means a State Children's Health Insurance Program under Titles XIX and XXI of the Social Security Act.

2.5 Claims Administrator. The "Claims Administrator" is (i) the third-party organization or individual to which the Plan Administrator has delegated the duty to process and review claims for benefits, decide appeals of denied claims for benefits, and facilitate external review of denied claims for benefits, if required by applicable law, for the Self-Insured Health Benefit Options, (ii) the Insurer for the Insurance Policies under the Insured Health Benefit Options.

2.6 COBRA. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, including applicable regulations.

2.7 Code. The "Code" is the Internal Revenue Code of 1986, as amended from time to time, including applicable regulations for the specified section of the Code.

2.8 Common Control. A trade or business entity (whether corporation, partnership, sole proprietorship or otherwise) is under "Common Control" with another trade or business entity (i) if both entities are corporations which are members of a controlled group of corporations as defined in §414(b) of the Code, (ii) if both entities are trades or businesses (whether or not incorporated) which are under common control as defined in §414(c) of said Code, (iii) if both entities are members of an affiliated service group as defined in §414(m) of the Code, or (iv) if both entities are required to be aggregated pursuant to regulations under §414(o) of the Code.

2.9 Company. The "Company" is Wells Fargo & Company, a Delaware corporation, and any successor thereof.

2.10 Dependent. A "Dependent" is any person who meets the requirements of an eligible dependent as stated in the Summary Plan Description and is enrolled in the Plan as a covered dependent. For purposes of this Plan Statement, an Alternate Recipient as defined in Section 3.6 of this Plan Statement is a Dependent.

2.11 Employee. An "Employee" is any employee of the Employer who is on the Employer's U.S. payroll, as described in the Summary Plan Description, subject to the following: (1) An employee is not an Employee prior to the date their employer becomes a Participating Employer; (2) A nonresident alien while not receiving earned income (within the meaning of section 911(d)(2) of the Code) from Employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3) of the Code) is not an Employee; (3) an individual will be deemed to be an Employee during an approved leave of absence from active service for a period up to twenty-four (24) continuous months (unless otherwise authorized by the Employer), provided that the individual was an Employee at the commencement of the period of absence; (4) an individual who, during any period during which the individual is classified by the Employer as an independent contractor or any other status in which the person is not treated as a common law employee of Employer for purposes of federal withholding of taxes, or is treated as an employee of another entity who is leased to Employer, regardless of the correct legal status of the individual, is not an Employee (this subsection (4) applies to all periods of service of an individual who is subsequently reclassified as an employee whether the reclassification is retroactive or prospective); (5) an employee designated as an "inpatriate" is not an Employee; (6) an employee designated as a "third country national" is not an Employee; (7) an employee who is working in the Cayman Islands is not an Employee; and (8) An employee designated as a "U.S. expatriate" is an Employee for purposes of eligibility for the dental and vision Benefit Options identified in Exhibit A and

is not an Employee for purposes of eligibility for any medical Benefit Option identified in Exhibit A unless the U.S. expatriate's home address of record in the Employer's Human Resources Information System is within the fifty United States or District of Columbia and the U.S. expatriate is not enrolled in coverage under the Wells Fargo & Company International Plan.

2.12 Employer. The "Employer" is the Plan Sponsor, any Participating Employer, and any successor thereof that adopts the Plan.

2.13 Enrollment Process. The "Enrollment Process" is the process, as determined by the Plan Administrator, entered into by an individual eligible to become a Participant as a condition of participation in the Plan. The Plan Administrator shall prescribe enrollment forms (which may include electronic equivalencies or telephonic enrollment) that must be completed by a prescribed deadline prior to commencement or continuation of coverage under the Plan.

2.14 Enrollment Period. The "Enrollment Period" is the election period for enrolling in or changing benefits coverage, as determined by the Plan Administrator.

2.15 ERISA. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time, including applicable regulations for the specified section of ERISA.

2.16 HIPAA. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, including applicable regulations.

2.17 Health Maintenance Organizations. "Health Maintenance Organizations" or "HMOs" are organizations that provide insured health benefits and most medical services on a pre-paid basis through their network of doctors and facilities. HMOs are Insured Health Benefit Options.

2.18 Insurance Policy. An "Insurance Policy" or "Insurance Policies" are the insurance policy or policies, or other evidence of coverage (including HMO agreements) issued by the Insurer/HMO, providing health or other benefits under an Insured Health Benefit Option. The Insurance Policies for the Insured Health Benefit Options listed in Exhibit A are incorporated into and made a part of this Plan Statement.

2.19 Insured Health Benefit Option. An "Insured Health Benefit Option" is a Benefit Option under the Plan where covered Participants and Dependents are insured by an Insurer in consideration of a premium paid to such Insurer pursuant to an Insurance Policy. The Insurer, not the Plan Sponsor, the Plan, or its underlying Trusts, bears the risk of paying benefits provided under the Insured Health Benefit Option. HMOs are Insured Health Benefit Options.

2.20 Insurer. An "Insurer" is the entity or entities issuing the Insurance Policy.

2.21 Participant. A "Participant" is an Employee (including any Employee who is a Benefits Eligible Rehired Retiree) who becomes covered under the Plan in accordance with the provisions of Section 3.1 of this Plan Statement. An Employee who becomes covered under the Plan, and former Employees during their Severance Eligibility Period who are or who become covered under the Plan, shall be considered to continue as a Participant until their coverage is terminated in accordance with Section 3.3 of this Plan Statement. A "Participant" also includes an individual who is a qualified beneficiary for purposes of

COBRA, elects to enroll in COBRA continuation coverage and pays all required contributions for COBRA continuation coverage.

2.22 Participating Employer. A "Participating Employer" is the Company and each of the participating subsidiaries or Affiliates of the Company that are designated as a Participating Employer for purposes of this Plan by Wells Fargo & Company by written actions of the President, Chief Executive Officer, Head of Human Resources (or the functional equivalent title of the Company's most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the Company's most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), or its or their authorized delegate. A Participating Employer will cease to be a Participating Employer if: (i) the Company withdraws its consent permitting the Participating Employer to participate in the Plan; or (ii) the Participating Employer ceases to be an Affiliate.

2.23 Plan. The "Plan" is the plan established and maintained by the Plan Sponsor for the purpose of providing medical, dental and vision benefits to covered Employees and their Dependents, which is formally known as the "Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents)," and which is also commonly known as the "Wells Fargo & Company Health Plan" or the "Health Plan." It is intended that this Plan is an "employee welfare benefit plan" within the meaning of ERISA.

2.24 Plan Administrator. The "Plan Administrator" of the Plan for purposes of ERISA § 3(16)(A) is the Company's: Head of Human Resources (or the functional equivalent title of the Company's most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), and Head of Benefits (or the functional equivalent title of the most senior position in Human Resources over benefit plans and programs other than the Head of Human Resources and the Head of Total Rewards), each of whom, acting individually or jointly, may take action as the Plan Administrator, or its or their authorized delegate.

2.25 Plan Sponsor. The "Plan Sponsor" is the Company. The Plan Sponsor is the "plan sponsor" within the meaning of ERISA § 3(16)(B).

2.26 Plan Statement. The "Plan Statement" is this written document entitled the "Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents)" as may be amended from time to time. The Plan Statement is only one of several documents pursuant to which the Plan is established and maintained. These other documents include the Summary Plan Descriptions for the Self-Insured Health Benefit Options and the Insurance Policies for the Insured Health Benefit Options.

2.27 Plan Year. The "Plan Year" is each period of twelve (12) consecutive months beginning January 1 and ending the following December 31.

2.28 Predecessor Employer. A "Predecessor Employer" is any corporation, partnership, firm, or individual (referred to in this definition as an "entity") if a substantial part of the assets and employees of the entity are acquired by a Participating Employer, an Affiliate, or another Predecessor Employer and if the entity is so designated by the Company or its delegate. Any other employer shall be a Predecessor Employer if so required by regulations prescribed by the Secretary of the Treasury.

2.29 **Premium Payment Rules**. The "Premium Payment Rules" are the rules established by the Plan Administrator regarding payment of contributions for coverage by Participants as a condition of participation in the Plan. For COBRA Participants, the COBRA Participant will pay the required premium or other costs for coverage on an after-tax basis in a manner acceptable to the Plan Administrator as described in the Summary Plan Description.

2.30 **Self-Insured Health Benefit Option**. A "Self-Insured Health Benefit Option" is a Benefit Option under the Plan where covered Participants and Dependents are self-insured by the Plan. The Plan bears the primary risk of paying benefits for covered Participants and Dependents as provided under the Self-Insured Health Benefit Option. Each Self-Insured Health Benefit Option may be administered by one or more Claims Administrators as described in the Summary Plan Description for such Self-Insured Health Benefit Options.

2.31 **Severance Eligibility Period.** The "Severance Eligibility Period" is any such period as defined under the Wells Fargo & Company Severance Plan, as may be modified from time to time.

2.32 **Summary Plan Description**. A "Summary Plan Description" is a written summary of the Participant's benefits and rights under a Benefit Option. The Summary Plan Descriptions are incorporated into and made a part of the Plan Statement.

2.33 **Trust**. The "Trust" is any trust which is established pursuant to a trust agreement (hereinafter referred to as the "Trust Agreement") to provide for the holding, investment and administration of the assets and other funds of the Plan. If the provisions of the Plan Statement and the Trust Agreement are inconsistent or otherwise in conflict with the rights, duties, or obligations of the Trustee, the provisions of the Plan Statement control.

2.34 **Trustee.** The "Trustee" means the trustee of the Trust, as provided in the Trust Agreement. The Trustee shall administer the Trust assets in accordance with the terms and provisions of the Trust Agreement and the Plan Statement.

SECTION 3
ELIGIBILITY AND PARTICIPATION

3.1 **Eligibility**. Eligibility to participate in a Benefit Option shall be determined by the provisions of the Summary Plan Description. To the extent there is an inconsistency between an Insurance Policy and the Summary Plan Description with respect to Plan eligibility, the eligibility provisions of the Summary Plan Description shall govern. Eligibility provisions in an Insurance Policy that conflict with the Summary Plan Description shall be the responsibility of the Insurer.

(a) **Employees**. Each person who is an Employee, other than those Employees who are Benefits Eligible Rehired Retirees or within a Severance Eligibility Period, shall become a Participant on the first day after he or she has satisfied the applicable eligibility requirements of the Plan and has met any applicable waiting period set forth for any particular Benefit Option in the Summary Plan Description, provided that such person has enrolled according to Section 3.2 and makes all contributions required under Section 5.3 of

this Plan Statement, at the time and in the manner specified by the Plan Administrator. Any Employee enrolled in one or more Benefit Options shall be a Participant in this Plan but shall be entitled to receive only the specific benefits applicable to the Benefit Options for which such person is eligible and has enrolled.

(b) Dependents. The effective date of coverage for enrolled Dependents is determined by the effective date of the enrollment event as stated in the Summary Plan Description, provided that the Employee (including an Employee who is a Benefits Eligible Rehired Retiree, or Employee during their Severance Eligibility Period) has enrolled such Dependent according to Section 3.2 and makes all contributions required under Section 5.3 of this Plan Statement, at the time and in the manner specified by the Plan Administrator. Any Dependent enrolled in any one or more of such Benefit Options shall be entitled to receive only the specific benefits applicable to the Benefit Option for which such person is eligible and has been enrolled as a covered Dependent. Dependents of an Employee designated as a "U.S expatriate" are eligible to be enrolled in the Plan as a covered Dependent for the purposes of the dental and vision Benefit Options identified in Exhibit A. Dependents of an Employee designated as a "U.S expatriate" are not eligible to be enrolled in the Plan as a covered Dependent under a medical Benefit Option identified in Exhibit A unless the U.S. expatriate's home address of record in the Employer's Human Resources Information System is within the fifty United States or District of Columbia and the U.S. expatriate has enrolled in that medical Benefit Option under this Plan and is not enrolled in coverage under the Wells Fargo & Company International Plan (UnitedHealthcare Global – Expatriate Insurance).

(c) Benefits Eligible Rehired Retiree. Each Benefits Eligible Rehired Retiree shall become a Participant on the first day of the Benefits Eligible Rehired Retiree's re-employment, provided that such Benefits Eligible Rehired Retiree has enrolled according to Section 3.2 and makes all contributions required under Section 5.3 of this Plan Statement, at the time and in the manner specified by the Plan Administrator. Any Benefits Eligible Rehired Retiree enrolled in one or more Benefit Options shall be a Participant in this Plan but shall be entitled to receive only the specific benefits applicable to the Benefits Options for which such person is eligible and has enrolled.

(d) Former Employees during their Severance Eligibility Period. Each Employee who was a Participant in the Plan on the date immediately preceding the date their Severance Eligibility Period begins, continues to be eligible for the Plan through the last day of the month in which their Severance Eligibility Period ends. Any enrollment election in effect at the time their Severance Eligibility Period begins will continue pursuant to Section 3.2 of this Plan Statement provided the individual makes all contributions required under Section 5.3 of this Plan Statement at the time and in the manner specified by the Plan Administrator, unless coverage is modified as permitted by Section 3.3 of this Plan Statement. Any Employee enrolled in one or more Benefit Options during their Severance Eligibility Period shall be a Participant in this Plan as stated herein but shall be entitled to receive only the specific benefits effective as of the coverage dates applicable to the Benefit Options for which such person is eligible and has enrolled.

3.2 Enrollment. Each individual who is or will become eligible to become a Participant as provided in Section 3.1 and who desires to enroll as a Participant (including enrolling Dependents, if applicable) shall, as a condition of participation in the Plan, complete the Enrollment Process as communicated by the Plan Administrator. A Participant who is enrolled in a Benefit Option under the Plan (and such Participant's Dependents) will be automatically re-enrolled in the same Benefit Option for the subsequent Plan Year, unless the Participant affirmatively changes Benefit Options or coverage level or affirmatively waives coverage under a Benefit Option during the annual Enrollment Period, or the Plan Administrator requires the Participant to make an affirmative election as part of the Enrollment Process. If such Benefit Option is no longer available under the Plan in the subsequent Plan Year, the Participant (and such Participant's Dependents) may be re-enrolled in an alternative Benefit Option, as determined by the Plan Administrator. Employees within a Severance Eligibility Period are also eligible to complete the Enrollment Process (subject to all Plan provisions which may provide that elections for certain Benefit Options are automatic) during the Severance Eligibility Period.

3.3 Modifications of Coverage. The coverage of a Participant or Dependent may only be modified as provided in this Section 3.3.

(a) Change in Coverage. A Participant may change their enrollment in the Benefit Options under the Plan (and coverage of their Dependents in concert with the Participant's change in coverage, if applicable) in accordance with the applicable terms and conditions described in the Summary Plan Description subject, however, to the applicable provisions of the Premium Payment Rules.

(b) Termination of Coverage. A Participant will cease being a Participant in the Plan or any Benefit Option under the Plan, as applicable, and coverage under the Plan for the Participant and their covered Dependents shall terminate in accordance with the provisions of the Summary Plan Description.

3.4 Nondiscrimination. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirements imposed by the Code, the Plan Administrator may take such action as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Health status-related factors as defined by HIPAA shall not be considered in determining the applicable waiting period for coverage to become effective, applying any special rules for late enrollment or special enrollment, and determining any affiliation periods for HMO or other Insured Health Benefit Option. Similarly, a Participant's or Dependent's health status-related factors shall not be considered in determining a Participant's premiums or other amounts charged the Participant for initial or continued coverage.

3.5 Adopted Children. A Child who is adopted by or Placed for Adoption with a Participant shall be eligible to be enrolled as a Dependent under the same terms and conditions as apply in the case of natural children of Participants under the Plan, irrespective of whether the adoption has become final. For purposes of this Section 3.5, the following capitalized terms shall have the following meanings:

(a) Child. "Child" means an individual who has not turned age twenty-six (26) years as of the date such person is adopted or Placed for Adoption with a Participant.

(b) Placed for Adoption. "Placed for Adoption" means any placement for adoption of total or partial support of a Child in anticipation of adoption of such Child. The Child's placement for adoption terminates upon the termination of such legal obligation.

3.6 Medical Child Support Orders. Consistent with the provisions of ERISA Section 609(a) as adopted in the Omnibus Budget Reconciliation Act of 1993 and effective at the date hereof, the Plan shall provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order ("QMCSO"). For purposes of this Section 3.6, the following capitalized terms shall have the following meanings:

(a) Alternate Recipient. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan with respect to such Participant. Each Alternate Recipient shall be permitted to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

(b) Medical Child Support Order. "Medical Child Support Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under applicable state law which has the force and effect of law which:

(1) provides for child support with respect to a child of a Participant under the Plan or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law) and relates to benefits under the Plan; or

(2) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan.

(c) Qualified Medical Child Support Order. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive medical benefits for which a Participant is eligible under the Plan and which satisfies all of the following requirements:

(1) Names and Addresses. The Medical Child Support Order must clearly specify the name and last known mailing address (if any) of the Participant required to provide coverage and the name and mailing address of each Alternate Recipient covered by the Medical Child Support Order.

(2) Type of Coverage. The Medical Child Support Order must clearly specify a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.

(3) Coverage Period. The Medical Child Support Order must clearly specify the period to which the order applies.

(4) Plan Identity. The Medical Child Support Order must clearly specify each Benefit Option under the Plan to which it applies. In the absence of a named Benefit Option, if the order otherwise provides the information in Sections 3.6(c)(1)-(3), the Alternate Recipient will be enrolled in the Benefit Option(s) as described in the Summary Plan Description.

(5) Restrictions. The Medical Child Support Order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act (as added by the Omnibus Budget Reconciliation Act of1993). If the Alternate Recipient cannot access the same coverage as the Participant, the Participant's Benefit Option will be changed to a Benefit Option that provides access for both the Participant and the Alternate Recipient.

(6) Procedures. The Plan Administrator shall prescribe procedures for determining the qualifications of Medical Child Support Orders received consistent with the requirements of ERISA Section 609(a).

SECTION 4
BENEFITS

4.1 Schedule of Benefits. The applicable schedules of benefits provided under each Benefit Option under the Plan are set forth in the Summary Plan Description and/or Insurance Policy, as applicable, for each such Benefit Option and are incorporated into and made a part of this Plan Statement. The applicable schedules of benefits for each Benefit Option do not apply to any other Benefit Option unless otherwise specifically stated.

4.2 Coordination of Health Benefits.

(a) Coordination with other Health Plans. The applicable coordination of benefits provisions for the Plan are set forth in the Insurance Policies and/or the Summary Plan Descriptions and are incorporated into and made a part of this Plan Statement.

(b) Compliance with Assignment of Rights. Payment for benefits under the Plan will be made in accordance with any assignment of rights made by or on behalf of a Participant or Dependent to the extent required by a state plan for medical assistance approved under Title XIX of the Social Security Act ("Grants to States for Medical Assistance Programs") pursuant to section1912 (a)(1)(A) of such Act (as in effect on August 1, 1993).

(c) Enrollment and Provision of Benefits. The fact that an individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act ("Grants to States for Medical Assistance Programs") will not be taken into account by the Plan in enrolling an individual as a Participant or Dependent or in determining or making payments for benefits of an individual as a Participant or Dependent.

(d) Acquisition by States of Rights of Third Parties. To the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act ("Grants to States for Medical Assistance Programs"), payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant or Dependent to such payment for such items or services in any case where the Plan has a legal liability to make payments for items or services constituting such assistance.

(e) Coordination with Medicare. Except as otherwise provided in the Summary Plan Description, Medicare Parts A and B benefits will be primary to the extent permitted under applicable law, and this Plan shall be primary to Medicare Parts A and B only to the extent required by applicable law. Prescription drug coverage under the Plan shall not be coordinated with Medicare Part D.

(f) Coordination with TRICARE, CHIP and other Governmental Program. TRICARE benefits will be primary to the extent permitted under applicable law. This Plan shall be primary to benefits provided under TRICARE only to the extent required by applicable law. This Plan will be primary to CHIP to the extent required by applicable law. If a Participant is covered by a governmental program other than Medicare or TRICARE, that program will be primary, except as otherwise required by applicable law.

4.3 HIPAA Privacy and Security.

(a) Definitions. For purposes of this Section 4.3, the following terms shall have the meaning set forth below:

(1) Business Associate. "Business Associate" shall be defined as the term "business associate" in 45 C.F.R. §160.103.

(2) EPHI. "EPHI" shall have the same meaning as assigned the term "electronic protected health information" in 45 C.F.R. §164.103.

(3) HIPAA. "HIPAA" shall be defined as the Health Insurance Portability and Accountability Act of 1996. HIPAA regulations are contained in the Privacy Rule and Security Rule.

(4) HITECH Act. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act and any accompanying regulations.

(5) Individual. "Individual" means the person who is the subject of the health information created, received or maintained by the Plan or the Plan Sponsor. Individual will also include that person's Personal Representative as defined by 45 C.F.R. §164.502(g)(1).

(6) Omnibus Rule. "Omnibus Rule" means the final rule that was published January 25, 2013 by the Department of Health and Human Services to modify the HIPAA Privacy, Security and Enforcement Rules to implement statutory amendments under the HITECH Act to strengthen the privacy and security protection for individuals health information; modify the rule for Breach Notification for Unsecured Protected Health Information, and

to modify the HIPAA Privacy Rule to strengthen the privacy protections for genetic information by implementing section 105 of Title I of GINA; and make certain other modifications to the HIPAA Privacy, Security, Breach Notification and Enforcement rules to improve the workability and effectiveness and to increase flexibility for and decrease burden on regulated entities.

(7) Plan Sponsor. "Plan Sponsor" is Wells Fargo & Company or its designee.

(8) Privacy Rule. "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts §160 and 164, subparts A and E. Any reference to the Privacy Rule in this document means the Privacy Rule as modified by the Omnibus Rule.

(9) Protected Health Information or PHI. "Protected Health Information" or "PHI" shall be defined as Protected Health Information according to 45 C.F.R. §160.103. For purposes of this Section 4.4, PHI shall include EPHI.

(10) Security Incident. "Security Incident" means an incident as defined in 45 C.F.R. §164.304.

(11) Security Rule. "Security Rule" means the Security Standards and Implementation Specifications at 45 C.F.R. Parts 160 and 164, subparts A and C. Any reference to the Security Rule in this document means the Security Rule as modified by Omnibus Rule

(b) Use and Disclosure of Protected Health Information.

- The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including, but not limited to, health care treatment, payment for health care, health care operations and as required by law. The Corporate Benefits HIPAA Privacy Policies and Procedures will list the specific uses and disclosures of PHI that will be made by the Plan.

- The Plan will disclose PHI to the Plan Sponsor only upon receipt of written certification from the Plan Sponsor that (i) the Plan Statement has been amended to incorporate the provisions in this Section 4.3; and (ii) the Plan Sponsor agrees to implement the provisions in Section 4.3(c).

- The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests summary health information for the purpose of obtaining premium bids for coverage under the Plan, or modifying, amending, or terminating the Plan.

- The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

(c) Conditions Imposed on Plan Sponsor. Disclosure of PHI by the Plan to the Plan Sponsor shall only be permitted upon receipt of a written certification from the Plan Sponsor that the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors and Business Associates, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI received or created on behalf of the Plan and ensure that such individuals agree to implement reasonable and appropriate security measures to protect EPHI;
- Not use or disclose the information for employment-related actions and decisions;
- Not to use or disclose an Individual's PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the Individual;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this Section 4.3 of which it becomes aware;
- Make available PHI in accordance with 45 C.F.R. §164.524 and the HITECH Act, if and when applicable;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528 and the HITECH Act, if and when applicable;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation supported by reasonable and appropriate security measures is implemented between the Plan and Plan Sponsor, as required in 45 C.F.R.; §164.504(f)(2)(iii).

(d) Business Associates. The Plan may also disclose or authorize disclosure of PHI to Business Associates of the Plan provided there is an executed agreement between the Plan and the

Business Associate whereby the Business Associate agrees to maintain the privacy and security of the PHI as described in the Privacy Rule, the Security Rule, and the HITECH Act. Notwithstanding any other provision of this Plan Statement to the contrary, all services performed by a Business Associate for the Plan in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plan and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the Plan. If a Business Associate of the Plan performs any services that relate to eligibility and enrollment to the Plan, these services shall be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Plan.

(e) Firewalls. As a condition precedent to the use and/or disclosure of PHI as set forth in paragraph (b) above, firewalls have been set up to maintain the confidentiality of PHI.

(1) In accordance with the Privacy Rule, only certain classes of employees of the Plan Sponsor are authorized to have access to PHI. The classes of employees who have access to PHI from the Plan are listed in the Notice of HIPAA Privacy Rights, which is incorporated into and made a part of this Section 4.3. The employees who have access to PHI listed in the Notice of HIPAA Privacy Rights may only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan and/or as required or permitted by law.

(2) Any and all uses and/or disclosures of PHI by these classes of employees are subject to a minimum necessary rule, as defined in the HITECH Act and any further guidance issued under the HITECH Act, whereby the amount of information that is used or disclosed should be the minimum necessary to accomplish the purpose taking into consideration practical and technological limitations. The only exception to this rule shall occur when the use or disclosure of the information is authorized or mandatory under law.

(3) The Plan and Plan Sponsor shall utilize certain safeguards (administrative, technical, and physical) to ensure that PHI is protected from those who are not authorized to use and/or disclose PHI.

(f) Compliance.

(1) The designated Privacy Official and Security Official shall be appointed by resolution executed by the Plan Administrator.

(2) The Privacy Official will be responsible for the Plan's compliance with the Privacy Rule and the HITECH ACT. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Privacy Official shall have the authority to and be responsible for:

- Accepting and verifying the accuracy and completeness of any certification provided by the Plan Sponsor under this Section 4.3;

- Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the Plan Sponsor;

- Establishing and implementing formal policies and procedures designed to ensure the Plan complies with the Privacy Rule;

- Distribution of a Notice of HIPAA Privacy Rights in such form as determined by the Privacy Official from time to time, as well as the policies and procedures for addressing and documenting complaints (including possible sanctions);

- Establishing and overseeing proper training of the Plan or Plan Sponsor personnel who will have access to PHI; and

- Any other duty or responsibility that the Privacy Official, in their sole capacity, deems necessary or appropriate to comply with the Privacy Rule and the purposes of this Section 4.3.

(3) The Security Official will be responsible for the Plan's compliance with the Security Rule and the HITECH ACT. The Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Security Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Security Official, in accordance with Company's HIPAA Security Rule Governance Methodology, shall have the authority to and be responsible for:

- Accepting and verifying the accuracy and completeness of any certification provided by the Plan Sponsor under this Section 4.3;

- Establishing and implementing formal policies and procedures with respect to EPHI that are designed to ensure the Plan complies with the Security Rule;

- Establishing and overseeing proper training of the Plan or Plan Sponsor personnel who will have access to PHI and EPHI; and

- Any other duty or responsibility that the Security Official, in their sole capacity, deems necessary or appropriate to comply with the Security Rule and the purposes of this section 4.3.

(4) The Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Section 4.3. The process for filing a complaint against the Plan or an employee of the Plan Sponsor for noncompliance is described in the Notice of HIPAA Privacy Rights distributed by the Plan Administrator, which is incorporated into and made a part of this Section 4.3.

- To the extent possible, the Plan shall take appropriate action to mitigate known harmful effects of inappropriate use or disclosure of PHI.

- Complainants shall not be subject to intimidation, threats, coercion or retaliation as a result of filing a complaint.

- No Individual will be required to waive their rights under HIPAA as a condition of treatment, payment, enrollment in a health plan or eligibility for benefits.

(g) **EPHI Certification.** With respect to any EPHI (other than enrollment/disenrollment information and Summary Health Information, as defined in 45 C.F.R. §164.504(a), which are not subject to these restrictions) created, received, maintained or transmitted by Plan Sponsor and/or any employee listed in the Notice of HIPAA Privacy Rights from or on behalf of the Plan, Plan Sponsor agrees to the following requirements and limitations:

- **Subcontractors and Agents.** Plan Sponsor will ensure that any agents, including independent contractors and subcontractors, to whom EPHI is provided from the Plan, agree to implement reasonable and appropriate security measures to protect the EPHI.

- **Safeguards.** Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan, as required under the Security Rule.

- **Duty to Report Violations.** Plan Sponsor will report to the Plan any Security Incident, of which it becomes aware. For purposes of this reporting requirement, "Security Incident" shall not include inconsequential incidents that occur on a daily basis such as scans or "pings" that are not allowed past the Plan Sponsor's firewall.

- **Adequate Separation.** Plan Sponsor will ensure that the adequate separation supported by reasonable and appropriate security measures is implemented between the Plan, Plan Sponsor, and employees listed in the Notice of HIPAA Privacy Rights required in 45 C.F.R. § 164.504(f)(2)(iii).

(h) **Organized Health Care Arrangement.** The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Plan Sponsor.

(i) **Hybrid Entity Designation**. The Plan Administrator intends the Plan to be a Hybrid Entity in accordance with 45 C.F.R. § 164.504(b) and only those benefits that would be a covered health plan under 45 C.F.R. § 160.103 (if set forth as a separate plan) will constitute the health care components of the Plan. Any benefit offered by the Plan that would not be a covered health plan under 45 C.F.R. § 160.103 if provided through a separate plan is a non-health care component of the Hybrid Entity and is not subject to the Privacy Rule.

(j) **Interpretation and Limited Applicability**. This Section 4.3 serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner

to effectuate this purpose. Neither this Section 4.3 nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Section 4.3 are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

(k) Enrollment and Coverage Information Maintained on Wells Fargo Payroll System and Records. Any information maintained on the Company's payroll system and records related to an Employee's enrollment and coverage level in the Plan (including an Employee's election to participate in the Plan, the Employee's coverage level under the Plan, and information identifying the Employee's Dependents) shall be information held and maintained by the Company in its capacity as an employer and does not constitute PHI.

SECTION 5
FUNDING AND CONTRIBUTIONS

5.1 Funding Policy of Trust. The Plan Administrator or its designee shall establish a funding policy and method for the Plan that is consistent with the objectives of the Plan. This funding policy and method, as established and amended from time to time, shall be stated to any person or entity responsible for the investment of any portion of the Trust assets, so that such person or entity may coordinate investment policies of the Trust with such funding policy and method.

5.2 Benefit Funding. Plan benefits and expenses may be funded as follows:

(a) Self-Insured Health Benefit Options. Benefits and expenses under the Self-Insured Health Benefit Options may be paid from the Trust or the Employer's general assets.

(b) Insured Health Benefit Options. The Insurers or HMOs shall pay benefits under the Insured Health Benefit Options in accordance with the terms of the applicable Insurance Policy. Premiums for Insured Health Benefit Options may be paid from the Trust or the Employer's general assets.

(c) Funding. Nothing herein shall require the deposit of any Employer payments or contributions or Participant contributions to the Trust. Amounts, if deposited in the Trust, shall be held in accordance with the terms of such Trust, as in effect from time to time, and such amounts may be used for any Plan purposes. Nothing herein requires that contributions to the Trust be segregated or dedicated for the use of a particular Benefit Option, including the Benefit Option for which the contribution was made. Under any Self-Insured Health Benefit Option offering a health reimbursement account, the health reimbursement account is a notional bookkeeping entry, and (i) no specific funds will be set aside in an account (or otherwise segregated) for purposes of funding a health reimbursement account, (ii) no interest or earnings will be credited to a health reimbursement account, and (iii) any amounts allocated to a health reimbursement account are not vested and are subject to forfeiture. No Employee, former Employee, Participant, or Dependent, shall have any right to, or interest in, the assets of the

Plan Sponsor or any Employer, the assets of the Trust, or any other funding vehicle of the Plan.

(d) Plan Expenses. All fees and expenses incurred in connection with the operation and administration of the Plan may be paid out of the Trust or any other Plan asset to the extent that it is legally permissible for such fees and expenses to be so paid. The Plan Sponsor may, but is not required to, pay such fees and expenses directly. The Plan Sponsor may also advance amounts properly payable by the Plan or Trust and then obtain reimbursement from the Plan or Trust for such advances.

5.3 Participant Contributions. Participants shall be responsible for payment of applicable premiums and contributions to the Plan for coverage as may be specified from time to time as determined by the Plan Sponsor and the Premium Payment Rules. The Plan Sponsor may establish different contribution rates for different classes of Participants or Dependents for any Benefit Option. The Plan Sponsor may require that Employee contributions (including any contribution during a Severance Eligibility Period) shall be made by payroll deduction.

5.4 Employer Contributions. The Employer may pay such contributions to the Plan as may be determined from time to time by the Plan Sponsor. Employer contributions may be paid to the Trust or directly to any Insurer or Claims Administrator within such time as may be determined by the Plan Sponsor. Nothing herein shall require an Employer to make payments or contribute to the Plan or to pre-fund any benefit through the Trust or otherwise.

5.5 Insured Health Benefit Options. In the case of Insured Health Benefit Options, contributions, including contributions by Participants, shall be paid to the Insurers and HMOs at such time or times as shall be required to maintain the coverage in effect under the Insurance Policies. The liability of the Employer, Plan Sponsor, Plan, and Plan Administrator shall be limited to the payment of such premiums, and no Participant or Dependent shall have any claim or cause of action against the Employer, Plan Sponsor, Plan, or Plan Administrator on account of the failure of an Insurer or HMO to pay benefits under the Insurance Policies. Nothing in this Plan Statement shall be deemed to require the Plan, Plan Sponsor, or Plan Administrator to insure any of the benefits provided under the Plan. In the event that any Insurer pays dividends, rebates, demutualization proceeds, or similar payments, such amounts shall be paid to the Plan Sponsor or Employer to the extent permitted by law unless the Plan Sponsor or Employer elects to contribute such amount to the Plan.

5.6 Mistaken Contributions. To the extent that a contribution is made by a Participant pursuant to a mistake in fact or administrative error, the Employer may repay or collect from the Participant the amount necessary to correct such mistaken contribution, provided, however, that in no event shall such a correction be made more than 12 months following the mistake in fact.

5.7 Recovery of Improperly Paid Benefits.

(a) Errors and Mistakes. The Plan Administrator has the authority to correct errors and make equitable adjustments for mistakes made in the administration of the Plan. The Plan Administrator reserves the right to recover amounts from a Participant or a Dependent that have been improperly paid, directly or indirectly, to or on behalf of a Participant or Dependent as a result of an error or mistake, including administrative errors or mistakes. This recovery

may be accomplished by any combination of the following: (i) reprocessing of the claim(s), (ii) requiring that any overpayment be returned when requested by the Claims Administrator or the Plan Administrator on behalf of the Plan, or (iii) reducing or offsetting a future benefit payment by the amount of any overpayment, (iv) any other methods determined by the Plan Administrator.

To the extent such amounts are to be recovered from a third-party, the Participant or Dependent is required to cooperate and assist the Plan Administrator in recovering such amounts from the third-party.

To the extent the Participant or Dependent does not cooperate or the amount recovered is incomplete or unsatisfactory to the Plan Administrator, the Plan Administrator or its designee has the right to offset the Participant's or Dependent's future benefits under the Plan to recover the amounts that were improperly paid in the past to or on behalf of the Participant or Dependent. The Plan Administrator reserves the right to perform audits and other investigations to determine whether a Participant or Dependent, or someone or entity on the Participant's or Dependent's behalf, has been accidentally overpaid and may require the Participant or Dependent to cooperate in the audit or investigation as a condition for continued participation in the Plan, provided such action is permitted by ERISA or other applicable law. In addition, the Plan Administrator may permit Claims Administrators to engage in claims offsetting. Claims offsetting is the practice of reducing a benefit payment to a provider by the amount of an overpayment by the same provider with respect to another claim. Such offsetting may occur without regard to whether the overpayment was made with respect to the same Participant or Dependent and without regard to whether an overpayment was made with respect to a claim paid pursuant to this Plan or another plan.

(b) Misrepresentation, False Claims, or Fraudulent Activity. The Plan Administrator reserves the right to recover amounts from a Participant or Dependent that have been improperly paid, directly or indirectly, to or on behalf of a Participant or Dependent from the Plan for a Self-Insured Health Benefit Option as a result of misrepresentation, false claims, or fraudulent activity by the Participant or Dependent and/or the Participant's or Dependent's health care provider. The Plan Administrator reserves the right to (i) recoup applicable benefits payments from the Plan to the Participant or Dependent or the Participant's or Dependent's health care provider; (ii) impose sanctions against a Participant or Dependent (including termination of coverage if permitted by ERISA or other applicable law) if the Plan Administrator determines that the Participant or Dependent engaged in fraud or deceit against the Plan; (iii) perform audits and other investigations to determine whether a Participant or Dependent has engaged in fraud or deceit; and (iv) require the Participant or Dependent to cooperate in the audit or investigation as a condition for continued participation in the Plan, provided such action is permitted by ERISA or other applicable law.

The Plan Administrator reserves the right to retroactively cancel coverage of a Participant and their covered Dependents under the Plan if the Participant fails to pay any required premium or contribution or if the Participant or Dependent: (1) performs an act, practice or omission that constitutes fraud, or (2) makes an intentional misrepresentation of material fact. Under these circumstances, coverage may be retroactively terminated after the Plan Administrator provides at least thirty (30) days advance written notice to each individual who will lose coverage. If an

individual's coverage is retroactively terminated, then the individual may appeal the decision in accordance with the rescission appeal procedures established by the Plan Administrator and communicated in writing to the individual. The Plan Administrator shall be the named fiduciary and shall have the discretionary authority and responsibility to decide all factual and legal questions with respect to rescission of coverage under a Self-Insured Health Benefit Option or Insured Health Benefit Option.

5.8 Right to Suspend Employer Contributions. It is the expectation of the Employer that it will continue contributions to the Plan, but such continuance is not assumed as a contractual obligation of the Employer, and the right is reserved by the Employer at any time and from time to time to reduce, suspend or discontinue any or all Employer contributions.

5.9 Lost Participants. Each Participant is responsible for providing the Plan Administrator with the Participant's and each covered Dependent's current address. In the event that a Participant or Dependent becomes entitled to a payment under the Plan and such payment cannot be made because the current address according to the Plan Administrator's records is incorrect and the Plan Administrator cannot locate a Participant or Dependent who has an outstanding check representing payment for a claim under the Plan after a reasonable search, the Participant shall be deemed a "Lost Participant." If this should occur, the outstanding claim shall be considered forfeited and such amount may be used to offset any Company contributions or other benefits payable under the Plan. If such Participant subsequently presents the Plan Administrator with a valid claim for these benefits, such Participant shall be paid the amount that was treated as forfeited without interest.

SECTION 6
ADMINISTRATION OF THE PLAN

6.1 Administration.

(a) Self-Insured Health Benefit Options. The Plan Administrator shall control and manage the operation and administration of the Self-Insured Health Benefit Options and make all decisions and determinations thereto. The Plan Administrator, and any Claims Administrator to whom such authority has been delegated pursuant to this Section 6, shall have the discretionary authority and responsibility to decide all factual and legal questions under the Self-Insured Health Benefit Options, to interpret and administer the terms and conditions of the Self-Insured Health Benefit Options, decide all questions concerning the eligibility of any persons to participate or be enrolled as an eligible Dependent in the Self-Insured Health Benefit Options, grant or deny benefits under the Self-Insured Health Benefit Options, construe any ambiguous provision of the Self-Insured Health Benefit Options' documents, correct any defect, supply any omission, or reconcile any inconsistency as the Plan Administrator, in its discretion may determine. The Plan Administrator may delegate its administrative duties to one or more officers or employees of the Plan Sponsor, or to individuals or entities independent of the Plan Administrator. All interested parties may act and rely upon all information reported to them hereunder and need not inquire into the accuracy thereof, nor be charged with any notice to the contrary.

(b) **Insured Health Benefit Options**. The Insurers shall control and manage the operation and administration of their Insured Health Benefit Options under the Plan and make all benefit decisions and determinations thereto. The Insurers shall have the discretionary authority and responsibility to decide all factual and legal questions regarding benefits provided by their Insured Health Benefit Options under the Plan, to interpret and administer the terms and conditions of the Insured Health Benefit Options, construe any ambiguous provision of their Insured Health Benefit Options' documents, correct any defect, supply any omission, or reconcile any inconsistency as the Insurer, in its discretion may determine on behalf of their Insured Health Benefit Options. Notwithstanding the above, the Plan Administrator shall continue to decide all questions concerning the eligibility of any persons to participate in the Plan, including Insured Health Benefit Options offered under the Plan.

(c) **Delegation**. For purposes of operation and administration of the Plan, the Plan Administrator may delegate any duties or responsibilities that properly belong to the Plan Administrator under the terms of the Plan document or ERISA, including without limitation the following:

(1) Appoint one or more committees (each a "Committee"), subcommittees of a Committee (whose members need not be members of the Committee), or otherwise appoint other individuals or departments at Wells Fargo & Company and determine their powers;

(2) Employ legal or other counsel and agents; and

(3) Obtain clerical, accounting, claims administration, and actuarial assistance.

6.2 **Rules and Regulations**. The Plan Administrator may adopt any rule not in conflict or at variance with the provisions of the Plan Statement. The rules, regulations, interpretations and determinations made by the Plan Administrator or any authorized person shall, subject only to the Plan Statement's claims procedures, be final and binding on Plan Participants and Dependents. The validity of any such rules, regulations, interpretations, and construction of the terms of the Plan Statement and determination of Plan issues shall be given deferential review if challenged in court, by arbitration, or in any other forum, and shall be upheld unless clearly arbitrary or capricious.

6.3 **Method of Executing Instruments**. Information to be supplied or written notices to be made or consents to be given by the Plan Sponsor pursuant to any provision of the Plan Statement may be signed in the name of the Plan Sponsor by any officer or by any employee who has been authorized to make such certification or to give such notices or consents.

6.4 **Facility of Payment.** In case of the legal disability, including minority age, of a Participant or Dependent entitled to receive any direct payment under the Plan, payment shall be made, if the Claims Administrator shall be advised of the existence of such condition:

(a) to the duly appointed guardian, conservator or other legal representative of such Participant or Dependent, or

(b) to a person or institution entrusted with the care or maintenance of the incompetent or disabled Participant or Dependent, provided such person or institution has satisfied the Claims

Administrator that the payment will be used for the best interest and assist in the care of such Participant or Dependent, and provided further, that no prior claim for said payment has been made by a duly appointed guardian, conservator or other legal representative of such Participant or Dependent.

Any payment made in accordance with the foregoing provisions of this Section shall constitute a complete discharge of any liability or obligation of the Plan Sponsor, the Plan Administrator and the Plan therefore. In the event of the death of the Participant or Dependent, claims for expenses incurred prior to the Participant's or Dependent's death may be presented by the personal representative of the Participant's or Dependent's estate and reimbursements not completed at death shall be made to the personal representative.

6.5 Information Furnished by Participants or Dependents. Neither the Plan Sponsor, the Plan Administrator or the Claims Administrators shall be liable or responsible for any error in the computation of the benefits of a Participant or Dependent resulting from any misstatement of fact or law made by the Participant or Dependent, directly or indirectly to the Plan Sponsor, Plan Administrator or Claims Administrator and used by it in determining the Participant's or Dependent's benefits. The Plan, Plan Sponsor, the Plan Administrator or the Claims Administrators shall not be obligated or required to increase the benefits of such Participant or Dependent which, on discovery of the misstatement, is found to be understated as a result of such misstatement of the Participant or Dependent. However, the benefits of any Participant or Dependent which are overstated by reason of any such misstatement shall be reduced to the amount appropriate in view of the truth.

6.6 Reliance on Reports, Certificates, and Participant Information. The Plan Administrator shall be entitled to rely conclusively upon all tables, valuations, certificates, opinions, and reports which will be furnished by an actuary, accountant, controller, counsel, Insurance Company, Claims Administrator, or other person who is employed or engaged for such purposes. Moreover, the Plan Administrator and Company shall be entitled to rely upon information furnished to the Plan Administrator or Company by a Participant or Dependent, including such person's current mailing address.

6.7 Indemnity. Except as prohibited by applicable law, the Plan Sponsor shall indemnify, to the extent not covered by insurance, any director, officer or employee of the Company who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether under the terms of ERISA or otherwise, wherever brought, whether civil, criminal, administrative or investigative by reason of the fact that the individual is or was a fiduciary or Plan Administrator of this Plan or by reason of acting in any other capacity in connection with this Plan, against expenses, including attorneys' fees, judgments, fines and amounts paid in settlement, actually and reasonably incurred by the individual in connection with such action, suit or proceeding if the individual acted in good faith, was not grossly negligent, and, with respect to any criminal action or proceeding, had no reasonable cause to believe the individual's conduct was unlawful. In no event shall this indemnification apply to liability that arises from the individual's claim for their own benefit. The termination of any action, suit or proceeding by judgment, order, settlement, conviction or upon a plea of nolo contendere or its equivalent, shall not, of itself create a presumption that the person did not act in good faith, was grossly negligent and, with respect to any criminal action or proceeding, had reasonable cause to believe that the individual's conduct was unlawful. The indemnification provided by this resolution shall continue as to a person who has ceased to be a director, officer, employee or agent and shall inure to the benefit of the heirs, executors and administrators of such a person.

6.8 **Service of Legal Process**. The Corporate Secretary of the Plan Sponsor is designated as the appropriate agent for the receipt of service of legal process directed to the Plan in any legal proceeding, including arbitration, involving the Plan. Service of legal process may also be made upon the Plan Administrator through the Company's Corporate Benefits Department.

6.9 **Third Party Liability**. The Self-Insured Health Benefit Options do not cover expenses a Participant or Dependent incurs as a result of an injury or other condition caused by a third party, to the extent such expenses are covered by money the Participant or Dependent receives from any persons, organizations, or insurers by way of settlement, verdict, judgment, award or otherwise on account of injury or other condition caused by a third party and such expenses do not exceed the applicable limitations under the applicable Self-Insured Health Benefit Option. There are two methods the Health Plan may use to recover the value of the health benefits paid for or provided to a Participant or Dependent in the event the Participant or Dependent has an injury or other condition caused by a third party: reimbursement and subrogation.

This described right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, medical payments coverage, other substitute coverage, or any other right of recovery, whether based on tort, contract, equity, or any other theory of recovery. The Health Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, noneconomic damages, and general damages, or a combination of the above, only. The right of reimbursement is binding upon the applicable Participant or Dependent, their legal representative, their heirs, next of kin, and any trustee or legal representative of such heirs or next of kin in the event of the affected Participant's or Dependent's death. Any amounts received from such a recovery must be held in trust for the Health Plan's benefit to the extent of subrogation or reimbursement claims. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made from such constructive trust until the Health Plan's subrogation and reimbursement interests are fully satisfied. Covered Participants and Dependents agree to cooperate fully in every effort by the Health Plan to enforce the rights of reimbursement and subrogation and agree not to do anything to interfere with those rights. Covered Participants and Dependents agree to inform the Health Plan in writing within thirty (30) days of giving notice to any party, including an insurance company or attorney, of their intention to pursue or investigate a claim to recover damages of obtain compensation due to their injury, illness or condition. Covered Participants and Dependents (and their agents) also agree to provide written notice to the Health Plan prior to receipt of any recovery or within five (5) days if no notice was given prior to their receipt of the funds.

The specific requirements of a Self-Insured Health Benefit Option's method of recovery are described in the applicable Summary Plan Description for the Benefit Option. The provisions of subsections 6.9(a) and (b) shall apply to the extent that the Summary Plan Description does not include the requirements of reimbursement or subrogation described in subsections 6.9 (a) and (b). The method of recovery (including any reimbursement or subrogation rights) of the Insured Health Benefit Options shall be specified in the Insurance Policies.

In the event that any claim is made that any part of this Section 6.9 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 Section.

By accepting benefits (whether the payment of such benefits is made to the Participant, Dependent or on their behalf to any provider) from the Health Plan, the affected Participant or Dependent agrees that any court proceeding with respect to this Section 6.9 may be brought in any court of competent jurisdiction and the Health Plan or its designee may elect. By accepting such benefits, the affected Participant or Dependent hereby submits to each such jurisdiction, waiving whatever rights may correspond to the affected Participant or Dependent by reason of present or future domicile.

(a) **Reimbursement policy**. As a condition of participation or enrollment in a Self-Insured Health Benefit Option, Participants and Dependents must agree to reimburse the Health Plan any money the Participant or Dependent receives through settlement, verdict, judgment, award or otherwise from an insurance company or otherwise for an injury or other condition caused by a third party. The Health Plan will not cover the value of the services to treat such an injury or condition, or the treatment of such an injury or condition, if a third party caused such injury or condition. The Health Plan may, however, advance payment to the Participant or Dependent for applicable expenses if the Participant or Dependent (or any person claiming through or on behalf of the Participant or Dependent) agrees:

(1) that the Health Plan has a first priority lien against any proceeds of any settlement, verdict, judgment, award, insurance proceeds or otherwise the Participant or Dependent receives, or that are received on behalf of the Participant or Dependent, as a result of the third party's actions and are to be repaid to the Health Plan before the Participant or Dependent receives any recovery for their damages;

(2) that the lien constitutes a charge upon the proceeds of any recovery and the Health Plan is entitled to assert a security interest on the lien;

(3) that by accepting benefits under the Health Plan the Participant or Dependent (or any person claiming through or on behalf of the Participant or Dependent) will hold the proceeds of any settlement in trust for the benefit of the Health Plan to the extent of 100% of all benefits paid on the Participant's or Dependent's behalf; and

(4) to assign to the Health Plan any benefits the Participant or Dependent may receive under any automobile policy or other insurance coverage, to the full extent of the Health Plan's claim for reimbursement.

The Participant or Dependent must sign and deliver to the Claims Administrator or the Plan Administrator on behalf of the Health Plan, as directed, any documents needed to protect the Health Plan's lien or to effect the assignment of the Participant's or Dependent's benefits. The Participant or Dependent must also agree not to take any action that is inconsistent with the Health Plan's right to reimbursement. The reimbursement will be made regardless of whether the Participant or Dependent is fully compensated by settlement, verdict, judgment, award or insurance proceeds, and this right of recovery will not be defeated or reduced by the application of any so-called "Make Whole Doctrine" or such doctrine purporting to defeat the Health Plan's recovery rights by allocating proceeds exclusively to nonmedical damages. In addition, the Health Plan is entitled to recover the full amount regardless of any claim of fault on the part of the Participant or Dependent, whether under comparative negligence or

otherwise. The Health Plan is not responsible for bearing the costs of any legal fees the Participant or Dependent may incur as a result of any action the Participant or Dependent takes against the third party.

By allowing the Health Plan to advance payment of benefits under a Self-Insured Benefit Option and by accepting such advance payment, the Participant or Dependent agrees that the Participant or Dependent will not make any settlement with a third party that specifically reduces or excludes or attempts to reduce or exclude the amount advanced by the Health Plan on the Participant's or Dependent's behalf. If the Participant or Dependent refuses to fully reimburse the Health Plan after receipt of a settlement, verdict, judgment, award or insurance proceeds, the Health Plan may not pay any future expenses, whether anticipated or unanticipated, relating to the Participant's or Dependent's injury or condition. In addition, the Health Plan may seek legal action against the Participant or Dependent to recover paid health benefits related to the Participant's or Dependent's injury or condition caused by a third party. In addition, the Health Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extend covered expenses are paid by the Health Plan.

Attorneys' fees and expenses that a Participant or Dependent incurs in connection with the recovery of money from third parties may not be deducted from 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 a Participant or Dependent or on their behalf.

(b) <u>Subrogation</u>. The Health Plan, or its agents, may directly assert its rights against a third party through subrogation, and the Health Plan will be subrogated to all of the Participant's or Dependent's rights against any third party who is liable for their injury or condition. The Health Plan may also be subrogated for the payment for the treatment of a Participant's or Dependent's injury or condition, to the extent of the value of the benefits provided to such Participant or Dependent by the Health Plan. The Health Plan may make a claim in the Participant's or Dependent's name or the Health Plan's name against any persons, organizations, or insurers on account of such injury or condition. At its sole discretion, the Health Plan may assert this right independently of a Participant or Dependent. The Participant or Dependent is obligated to cooperate with the Health Plan and its agents to protect the Health Plan's subrogation rights. Cooperation means (i) providing the Health Plan, or its agents with any relevant information as requested, (ii) signing and delivering such documents as the Health Plan or its agents request to secure the Health Plan's subrogation claim, and (iii) obtaining the Health Plan's consent, or its agent's consent, before releasing any third party from liability for payment of the Participant's or Dependent's applicable medical, dental or vision expenses. If the Participant or Dependent enters into litigation or settlement negotiations regarding the obligations of other parties, the Participant or Dependent must not prejudice, in any way, the subrogation rights of the Health Plan. Any costs incurred by the Health Plan in matters related to subrogation may be paid for by the Health Plan. The costs of the Participant's or Dependent's legal representation will be the responsibility of the Participant or the Dependent; the Plan is not responsible.

Attorneys' fees and expenses that a Participant or Dependent incurs in connection with the recovery of money from third parties may not be deducted from subrogation 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 a Participant or Dependent or on their behalf.

SECTION 7
CLAIMS AND APPEALS

For purposes of this Section 7, a "Claim for Benefits" is a claim for benefits made by a claimant (or their authorized representative) in accordance with the procedures under the terms of the applicable Benefit Option. Casual inquiries about benefits or the circumstances under which benefits might be available under the Plan are not "Claims for Benefits" for purposes of this Section 7.

Claims for Benefits under an Insured Health Benefit Option are to be filed with the Insurer according to the terms of the applicable Insurance Policy. Appeals of denied Claims for Benefits under an Insured Health Benefit Option are to be filed with the Insurer according to the terms of the applicable Insurance Policy. The Insurer will have the discretionary authority to interpret the terms of the Plan and Insurance Policy with respect to such Insured Health Benefit Option.

Claims for Benefits under a Self-Insured Health Benefit Option are to be filed with the Claims Administrator according to the terms of the Summary Plan Description for such Self-Insured Health Benefit Option. Appeals of denied Claims for Benefits under a Self-Insured Health Benefit Option are to be filed with the Claims Administrator according to the terms of the applicable Summary Plan Description. The claims and appeals procedures of the applicable Summary Plan Descriptions are incorporated into and made a part of this Plan Statement. The Claims Administrator will have the discretionary authority to interpret the terms of the Plan, including the Summary Plan Description, with respect to such Self-Insured Health Benefit Option.

The Claims Administrator shall be the ultimate claims fiduciary for all internal appeals for denied Claims for Benefits under a Self-Insured Health Benefit Option. With respect to vision or dental claims under a Self-Insured Health Benefit Option, the Claims Administrator shall be the ultimate claims fiduciary for all appeals for denied Claims for Benefits where such claims are incurred on or after January 1, 2011.

SECTION 8
AMENDMENT AND TERMINATION

8.1 **Amendment**. The Company, by action of the Board of Directors of the Company (the "Board"), by action of the Human Resources Committee of the Board, or by action of a person so authorized by resolution of the Board or the Human Resources Committee of the Board, may amend the Plan at any time, for any reason, with or without notice. In addition, the Company's: Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), or their delegate, may execute a written action amending the Plan in any of the following respects:

(a) To amend the Plan to comply with changes in applicable laws or regulations;

(b) To add or amend the Exhibits of the Plan; or

(c) To make changes in administration or operation of the Plan to the extent that such changes constitute an amendment to the Plan, which do not materially increase the cost of the Plan to the Company.

All such amendments shall be binding on all Participating Employers.

8.2 **Termination of the Plan**. The Board of Directors of the Company may terminate the Plan at any time, for any reason, with or without notice. In addition, the Company, by written action of its President, Chief Executive Officer, Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), or their delegate, may terminate the Plan at any time, for any reason, with or without notice as it applies to a particular Participating Employer, subject to any limitations specified in the applicable resolutions adopted by the Board of Directors of the Company.

SECTION 9
MISCELLANEOUS

9.1 **Plan Sponsor**. Functions generally assigned to the Plan Sponsor shall be discharged by its officers or delegated and allocated as provided herein. The Plan Sponsor's President, Chief Executive Officer, Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), or Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), may delegate or redelegate and allocate or reallocate to one or more persons or to a committee of persons jointly or severally, whether or not such persons are officers or Employees, such functions assigned to the Plan Sponsor hereunder as it may from time to time deem advisable.

9.2 **Limitation and Authority**. No action taken by any fiduciary, if authority to take such action has been delegated or redelegated to it hereunder, shall be the responsibility of any other fiduciary except as may be required by ERISA. Except to the extent imposed by ERISA, no fiduciary shall have the duty to

question whether any other fiduciary is fulfilling all of the responsibility imposed upon such other fiduciary by the Plan Statement or by ERISA or by any regulations or rulings issued thereunder.

9.3 Fiduciary Principles. Each fiduciary hereunder, in the exercise of each and every power or discretion vested in them by the provisions of the Plan Statement, shall (subject to the applicable provisions of ERISA) discharge their duties with respect to the Plan solely in the interest of the Participants:

(a) for the exclusive purpose of providing benefits to Participants and Dependents;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan insofar as they are consistent with the provisions of applicable law.

9.4 Conflict of Interest. If any employee or officer of the Plan Sponsor to whom authority has been delegated or redelegated hereunder shall also be a Participant or Dependent in the Plan, the individual shall have no authority as such member, officer or employee with respect to any matter specially affecting their individual interest hereunder (as distinguished from the interests of all Participants or a broad class of Participants or Dependents), all such authority being reserved exclusively to the other members, officers or employees, as the case may be, to the exclusion of such Participant or Dependent, and such Participant or Dependent shall act only in their individual capacity in connection with any such matter.

9.5 Dual Capacity. Individuals, firms, corporations or partnerships identified herein or delegated or allocated authority or responsibility hereunder may serve in more than one capacity.

9.6 Named Fiduciaries. The Plan Administrator is the "named fiduciary" of the Plan with authority to control and manage the operation and administration of the Plan, within the meaning of ERISA section 402(a)(2). For each Insured Health Benefit Option, the applicable Insurer shall be the "named fiduciary" of the Plan within the meaning of section 402(a)(2) of ERISA, and shall have authority to control and manage the operation and administration of the Plan with respect to claim determinations for such Insured Health Benefit Option. For each Self-Insured Health Benefit Option, the applicable Claims Administrator shall be the "named fiduciary" of the Plan within the meaning of section 402(a)(2) of ERISA, and shall have authority to control and manage the operation and administration of the Plan with respect to claim determinations for such Self-Insured Health Benefit Option. Notwithstanding the above, the Plan Administrator, or its designee, shall continue to decide all questions concerning the eligibility of any persons to participate or be enrolled as a Dependent in the Plan.

9.7 Spendthrift Provision. No Participant or Dependent shall have any transmissible interest in any benefit under the Plan nor shall any Participant or Dependent have any power to anticipate, alienate, dispose of, pledge or encumber the same, nor shall the Employer recognize any assignment thereof, either in whole or in part, nor shall any benefit be subject to attachment, garnishment, execution following judgment or other legal process, provided that a Participant or Dependent may authorize, to the extent anticipated by the applicable provisions of the Plan Statement, that benefits due or receivable under the

Plan be made available to the facility or other provider furnishing services for which such benefits are payable.

9.8 Construed as a Whole. The provisions of the Plan shall be construed as a whole in such manner as to carry out the provisions thereof and shall not be construed separately without relation to the context.

9.9 Plan Identification Number. The Plan Identification Number that has been assigned to the Plan is 537.

SECTION 10
DISCLAIMERS

10.1 No Employment Rights. Neither the terms of the Plan Statement nor the benefits hereunder nor the continuance thereof shall be a term of the employment of any Employee, and the Employer shall not be obliged to continue the Plan. The terms of the Plan Statement shall not give any Employee the right to be retained in the employment of the Employer, and it does not change any employment policies of the Employer.

10.2 No Guarantee. Neither the members of any committee appointed by the Employer nor any of the Employer's officers in any way secure or guarantee the payment of any benefit or amount which may become due and payable hereunder to any Participant or Dependent. Each Participant or Dependent entitled at any time to payments under one of the Self-Insured Health Benefit Options of the Plan shall look solely to the assets of the Plan for such payments. Each Participant or Dependent entitled at any time to payments under an Insured Health Benefit Option of the Plan shall look solely to the Insurer, and not to the Plan, Plan Administrator or Plan Sponsor, for the payment of such benefits. Neither the members of any committee nor any of the Employer's officers shall be under any liability or responsibility (except to the extent that liability is imposed under ERISA) for failure to effect any of the objectives or purposes of the Plan by reason of the insolvency of the Plan Sponsor or any Insurer.

10.3 No Co-Responsibility. Except as is otherwise provided in ERISA, no fiduciary shall be liable for an act or omission of another person with regard to a fiduciary responsibility that has been allocated to or delegated in the Plan Statement or pursuant to procedures set forth in the Plan Statement.

[*signature page follows*]

IN WITNESS WHEREOF, Wells Fargo & Company hereby amends and restates the Wells Fargo & Company Health Plan (for eligible active employees and their dependents) effective January 1, 2024, and has caused this Instrument to be executed by the authorized person signed below.

WELLS FARGO & COMPANY

By: DocuSigned by: Daniela Nese EAB46AE8FD5B48A... _____

Daniela Nese
Head of Benefits

Date: 3/4/2024 _____

EXHIBIT A
Benefit Options

Effective January 1, 2024, the Wells Fargo & Company Health Plan's Benefit Options are:

Benefit Option (benefits)	Funding	Administration
Copay Plan with Health Reimbursement Account (HRA), also known as "Copay Plan with HRA" (medical and prescription drug coverage)[1]	Self-Insured Health Benefit Option	Third-Party Administrator
HSA Plan	Self-Insured Health Benefit Option	Third-Party Administrator
Local Network Copay Plan with HRA (medical and prescription drug coverage)[1]	Self-Insured Health Benefit Option	Third-Party Administrator
Flexible High Deductible Health Plan, also known as "Flex HDHP" (medical and prescription drug coverage)	Self-Insured Health Benefit Option	Third-Party Administrator
HMO – Kaiser California, Colorado, Maryland, Oregon, Virginia, Washington, and the District of Columbia (Washington, D.C.) also known as HMO – Kaiser (medical and prescription drug coverage)	Insured Health Benefit Options	Insurer
POS Kaiser Added Choice – Hawaii, also known as Kaiser POS and Kaiser Hawaii (medical and prescription drug coverage)	Insured Health Benefit Option	Insurer
Delta Dental Standard and Enhanced, commonly referred to as the "dental plan" (dental coverage)	Self-Insured Health Benefit Options	Third-Party Administrator
Vision Service Plan, commonly referred to as the "vision plan" (vision coverage)	Self-Insured Health Benefit Option	Third-Party Administrator

Effective July 1, 2022, the Self-Insured Health Benefit Options under the Plan include reimbursement for travel and lodging expenses related to covered and legal abortion services. Such reimbursement for travel and lodging expenses shall be administered in accordance with Internal Revenue Code Section 213(d), applicable guidance issued thereunder and any other applicable law.

[1] For Participants enrolled in the Copay Plan with HRA or Local Network Copay Plan with HRA effective February 1, 2024, with salary reductions to pay for such coverage under the Wells Fargo & Company 2024 Flexible Benefits Plan for Certain Eligible Employees, such Participants will not forfeit amounts in their HRA as of December 31, 2023, due to a gap in coverage in January 2024.

EXHIBIT B

WELLS FARGO

Benefits Book

A guide to your Wells Fargo benefits

Effective January 1, 2024

Use this guide to review eligibility information, plan coverage details, important notifications and disclosures, and more.

This book is meant for eligible employees on U.S. payroll.

Contents

Chapter 1: Eligibility, Enrollment, and More

Contents

Benefit plan options

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

- Regular
- Fixed term
- Flexible
- Intern

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

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

Benefit plan options available to regular and fixed term employees

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

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

Benefit plan option available to interns and flexible employees

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

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

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

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

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

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

- If you are currently enrolled in a Wells Fargo-sponsored group health plan, the child will be added to the same health plan, if possible.
- If the child does not live with you, your current plan may not be available where your child lives. In this case, if the order has not identified another medical plan option, you and the child will be enrolled in the Copay Plan with HRA, which is available in all 50 states within the United States except Hawaii.
- You cannot drop coverage, including coverage for an alternate recipient, while a QMCSO is in force.
- If you are a regular or fixed term employee, you may change medical plan benefit options during Annual Benefits Enrollment, if the child is an eligible dependent under the new medical plan benefit option, by accessing the benefits enrollment site in Workday, or by calling Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.
- If coverage is provided pursuant to a QMCSO and that QMCSO is terminated by the court or issuing agency, that does not necessarily mean that coverage for you or your otherwise eligible child will end. Except where continuing coverage constitutes a violation of applicable law or issuing agency error (as determined in the discretion of the plan administrator), coverage will generally continue unless you experience a Qualified Event (as described in the SPD) that would allow you to drop your coverage or the child's coverage. You may elect to drop or change coverage during Annual Benefits Enrollment. For more information about changing or dropping coverage, see the "Changing coverage" section beginning on page 1-25.

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

Cost and funding

Cost

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

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

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

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

- **Tobacco-user status.** You designate your tobacco-user status on Workday when you enroll. Tobacco use includes, but is not limited to, cigarettes, electronic cigarettes, cigars, pipes, and chewing tobacco.
  - Your designated tobacco-status on Workday automatically impacts life insurance and medical premiums.
    - Tobacco users are required to pay a tobacco premium surcharge for medical coverage. See the "Cost" section in "Chapter 2: Medical Plans" for more information on the surcharge and the opportunity to have the surcharge waived.
  - Your designated tobacco-status on Workday does not automatically impact your Optional Critical Illness Insurance premiums; however, premiums are differentiated based on the coverage you elect (tobacco-user or non-tobacco user coverage option).
- **Level of coverage.** You elect one of the following levels of coverage if you choose to enroll in medical, dental, vision, optional critical illness, or optional accident insurance coverage:
  - You only
  - You and spouse or domestic partner
  - You and children
  - You and spouse or domestic partner and children
- **Medical premium compensation category.** For regular and fixed term employees, your contribution or premium amount for medical coverage will also vary based on your compensation category (for more information on compensation categories, see "Medical premium compensation category:" in the "Cost" section of "Chapter 2: Medical Plans").

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

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

Paying for coverage — regular and fixed term employees

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

If you enroll in benefits retroactive to your date of hire or employment classification change (or similar event that allows a retroactive coverage effective date), all benefit premium deductions will be deducted from your first applicable pay period following the date the retroactive enrollment was submitted as long as you have enough in your pay to cover the premium deductions. If you do not have enough in your paycheck, any remaining premium deductions owed will go into arrears and additional contributions, up to the extent permitted by applicable law, will be deducted from your pay until your outstanding past due balance is zero. If you still have an outstanding premium deduction and you are no longer enrolled in coverage, a flat amount of up to $125 per pay period will be deducted from your pay until your outstanding balance is zero, or at its discretion, the plan administrator (or its delegate) may inform you of additional actions that may be taken by it to address your past due balance.

Any change in contribution or premium due to an employment classification change:

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

Per-pay-period premiums and cost for coverage are not prorated.

If your pay is not sufficient to cover your costs for your benefit elections, you are still responsible for your contribution or premiums for coverage, including any retroactive contributions or premium adjustments. In some cases, you may be set up on a direct billing process to pay your required contributions and premiums on an after-tax basis. If you have an outstanding balance that is past due, additional contributions of up to the same per-pay-period amount as your current coverage may be deducted from your pay until your outstanding past due balance is zero. If you are no longer enrolled in coverage, a flat amount of up to $125 per pay period will be deducted from your pay until your outstanding past due balance is zero, or at its discretion, the plan administrator (or its delegate) may inform you of additional actions that may be taken by it to address your past due balance. If you are on a leave of absence, you may be billed directly.

Before-tax contributions

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

Exceptions:

- If you cover a domestic partner or their eligible children, your contributions or premiums for those individuals may not be before-tax, and Wells Fargo's contribution toward the cost of coverage for your domestic partner and their eligible children may be considered taxable income to you; see the "Tax implications for domestic partners" section starting on page 1-15 and consult a tax advisor.
- If you are a rehired retiree, your cost for medical, dental, and vision coverage under the Wells Fargo & Company Health Plan (or the Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance) (if applicable) will be on an after-tax basis from your date of rehire until the first of the month following one full calendar month of service with Wells Fargo. For example, if you are rehired on February 23, your contributions for your benefit elections will be on an after-tax basis through March 31. Effective April, your contributions for your benefit elections will be on a before-tax basis where applicable.

After-tax contributions

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

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

benefits, the benefit plan is responsible for paying claims.

HMO or insurer. When benefits are fully insured by an HMO
administering and paying benefits.

used for any health plan purposes. There is no requirement that
for a particular benefit option, including the benefit option for
employee, participant, dependent, or beneficiary will have any

Wells Fargo does not contribute to the flexible spending accounts. All contributions to the Full-Purpose Health Care Flexible Spending Account, the Limited Dental/Vision Flexible Spending Account, and the Day Care Flexible Spending Account
Wells Fargo.

For information on funding arrangements and benefits under the STD Plan, see "[illegible]: Short-Term Disabil[illegible]."

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

For benefits not funded through a trust, fees and expenses
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

General information

You may enroll online in the benefit plan options for which
at 1-877-HRWELLS (1-877-479-3557), option 2, within the

date, call Employee Care at 1-877-HRWELLS (1-877-479-3557), option 2.

[illegible] section starting on page 1-17 outlines the designated enrollment period and the coverage effective date
newly eligible for different benefits coverage when you have an applicable employment classification change, such as:

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

[illegible] Benefit plan options" section on page 1-4 [illegible] Initial enrollment — regular and fixed term [illegible] section on page 1-17 or the "[illegible] — interns and flexible employees" section on page 1-17 for [illegible] your employment classification (see the "[illegible]" section on page 1-5 for more information on employment classification). If you are a rehired employee, including an [illegible] section beginning on page 1-21 .

or domestic partner), you must also enroll them during your requirements; see the "[illegible]" on page 1-6. **Note:** dependent child who is age 26 or older, enrollment cannot be at 1-877-HRWELLS (1-877-479-3557), option 2, within your

different benefits coverage when you have an applicable employment classification change as noted in the "[illegible]" section on page 1-17. However, if you were already working for Wells Fargo as a local hire on local payroll (other than U.S. payroll) and you become a localized U.S.-based employee paid on the Wells Fargo U.S. payroll system, you will be contacted by Employee Care to review your applicable benefit your enrollment period and process your benefit elections.

[illegible] section starting on page 1-17), you will miss your opportunity to have benefits that require an benefits until the next Annual Benefits Enrollment period unless you experience an event that would allow you to enroll outside of the initial designated enrollment period. For more [illegible] on page 1-25.

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

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

Initial enrollment — regular and fixed term employees

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

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

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

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

Note: If you are rehired by Wells Fargo as a regular or fixed term employee with a first day of reemployment during your severance eligibility period under the Wells Fargo & Company Severance Plan, your enrollment options are different. See the "Rehired employees" section on page 1-21.

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

Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance)

If you become eligible to enroll in the Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance), you will receive enrollment materials that provide information about the initial enrollment process, the due date to complete enrollment, and the applicable effective date of coverage. You will not have another opportunity to enroll in benefits until the next Annual Benefits Enrollment period for this plan unless you experience an event that would allow you to enroll outside of the initial designated enrollment period for this plan. See the "Changing coverage" section beginning on page 1-25.

Initial enrollment — interns and flexible employees

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

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

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

When to enroll

You must enroll during your designated enrollment period:

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

Note: Your time to enroll ends at 11:59 p.m. Central time on the last day of the 30-day designated enrollment period. Take care in making your elections because after you have completed them, the online enrollment tool closes for those benefits. You cannot make any changes to your submitted elections during your 30-day designated enrollment period. However, you may still make additional elections for other benefits you did not submit elections for during your 30-day designated enrollment period. Be aware that making elections later in the 30-day designated enrollment period may delay your benefits ID cards and could result in retroactive premium deduction adjustments. Also, your claims administrator may not be aware of your enrollment on the date your benefits take effect.

with respect to a tobacco surcharge determination, you must first complete the internal administrative process described above. After completing the process, if you want to take legal action, you must do so within the statute of limitations described in the "Agent for service" section in "Appendix B: Important Notifications and Disclosures."

Payment adjustments for benefit coverage

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

- Coverage becomes effective for you, your dependents, or both, whether retroactively or prospectively, you are responsible for all contributions or premiums owed. For more information, refer to the "Cost and funding" section on page 1-13.
- Coverage is retroactively terminated, for you, your dependents, or both, any premiums paid after the coverage end date, for the coverage that is retroactively terminated, may be refunded on a future paycheck. Additional information may be required from you to retroactively terminate your benefits; if this is the case, more information will be provided at the time the determination is communicated.

When coverage begins

New employees

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

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

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

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

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

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

Your coverage effective date may vary in the following situations:

- If you are a regular or fixed term employee and are not actively at work on the date coverage would normally begin, your effective date for STD, Basic LTD, Optional LTD, Basic Term Life, Optional Term Life, Spouse/Partner Optional Term Life, Dependent Term Life, Basic Critical Illness Insurance, Optional Critical Illness Insurance, and Optional Accident Insurance coverage will be delayed until you return to work (you must return to work in a regular or fixed term position). See the applicable chapter for more information.
- Spouse/Partner Optional Term Life coverage, Dependent Term Life coverage, and dependents enrolled in Optional Critical Illness Insurance and Optional Accident Insurance coverage are subject to the nonconfinement clause as described in the "Delayed effective date" section of the applicable chapter.
- Amounts above guarantee issue for Optional Term Life and Spouse/Partner Optional Term Life are subject to Statement of Health approval by MetLife, as described in the "Statement of Health" section of "Chapter 7: Life Insurance Plan".
- If you are already working for Wells Fargo as a local hire on local payroll (other than U.S. payroll) and you become a localized U.S.-based employee paid on the Wells Fargo U.S. payroll system as a regular or fixed term employee, your coverage under the U.S. benefits as an employee becomes effective for medical, dental, vision, life insurance, legal services, and short- and long-term disability coverage the date you become a localized U.S.-based employee. All other benefits become effective the first of the month following the date you become a localized U.S.-based employee. However, if you are not actively at work on the date coverage would normally begin, your effective date for BTA, AD&D, STD, Basic LTD, Optional LTD, Basic Term Life, Optional Term Life, Spouse/Partner Optional Term Life, Dependent Term Life, Critical Illness Insurance, and Accident Insurance coverage will be delayed until you return to work on U.S. payroll (you must return to work in a regular or fixed term position).
- If you are already working for Wells Fargo as a local hire on local payroll (other than U.S. payroll) and you become a localized U.S.-based employee paid on the Wells Fargo U.S. payroll system as an intern or flexible employee, medical coverage under the U.S. benefits as an intern or flexible employee becomes effective the date you become a localized U.S.-based employee.

Dropping dependents during Annual Benefits Enrollment

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

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

If you have dropped a spouse, domestic partner, or other covered dependent during Annual Benefits Enrollment, you may not add them back to your coverage during the year unless you experience a corresponding Qualified Event or special enrollment event (see the "Changing coverage" section beginning on page 1-25).

Effective date

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

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

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

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

Effective date

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

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

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

Effective date

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

Dropping your coverage

You may drop your medical, dental, vision, legal services, life insurance, accidental death and dismemberment, optional critical illness insurance, or optional accident insurance coverage during the Annual Benefits Enrollment period. See the "Annual Benefits Enrollment" section beginning on page 1-26 for more information.

You may not drop your medical, dental, vision, and legal services coverage or your participation in a flexible spending account during the plan year unless you have a Qualified Event and your election to drop your coverage is consistent with the Qualified Event. If you don't have a Qualified Event during the plan year, you must wait until the next Annual Benefits Enrollment period to drop coverage. See the "Annual Benefits Enrollment" section beginning on page 1-26 and the "Qualified Events" section beginning on page 1-29 for more information.

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

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

Summary Plan Descriptions for each benefit plan

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

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

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

1. If the information provided by an insurer or HMO conflicts with the information listed in the applicable chapters or appendixes in this *Benefits Book*, the information in this book supersedes and is controlling.
2. Only the "Your rights under ERISA," "Plan information," "Participating employers," "Future of the plans" sections, and applicable portions of the "ERISA plans sponsored by Wells Fargo" table apply.

Chapter 2: Medical Plans

Contents

Changing or canceling coverage

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

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

When coverage ends

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

Cost

You must make contributions to pay for the cost of medical coverage for yourself and any covered dependents. If you enroll in a medical plan under the Wells Fargo & Company Health Plan, your cost for medical coverage will be determined by the following:

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

  * The term "spouse" includes your domestic partner
- Your tobacco-user status
  - Tobacco use includes, but is not limited to, cigarettes, electronic cigarettes, cigars, pipes, and chewing tobacco.
  - Employees who enroll in the medical plan options and who have identified themselves as tobacco users on Workday must pay a premium surcharge of $600 annually (applied pro rata as premium amounts are charged) for Wells Fargo medical plan coverage. To qualify for a credit of the entire tobacco surcharge for the 2024 plan year, impacted employees had to enroll in the Quit For Life® tobacco cessation program by December 14, 2023, as described in your annual enrollment materials. If an impacted employee enrolls in Quit For Life® after December 14, 2023, any tobacco surcharge credit will apply prospectively against future premium contributions. For more information on Quit For Life®, see, the "Quit For Life®" section on page 2-36. This program is voluntary and offered as part of the wellness program. An accommodation process is also available, as described in the "Requests for accommodations" section on page 2-36. **Note:** The surcharge does not apply to the Flex HDHP or the Wells Fargo & Company International Plan (UnitedHealthcare Global — Expatriate Insurance). The surcharge also does not apply to COBRA participants enrolled in any medical plan.
- If you are a regular or fixed term employee, your cost is also determined in part by your medical premium compensation category as described in the "Medical premium compensation category" section starting on this page.

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

Medical premium compensation category:

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

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

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

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

- **For Annual Benefits Enrollment elections**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical plan options

Insured medical plan options

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

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

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

Important Arbitration Notice for Kaiser California and Hawaii Employees

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

Insurer and claims administrator

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

Important terms

Annual deductible

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

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

The annual deductible is applied to the annual out-of-pocket maximum. The in-network and out-of-network annual deductibles and annual out-of-pocket maximums do not accumulate jointly. Therefore, charges for services in-network do not count toward your out-of-network annual deductible and annual out-of-pocket expenses and vice versa. However, for the Copay Plan with HRA, the Tier 1 and Tier 2 in-network deductibles do count toward each other (cross-accumulate). See the "Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum" section on page 2-17 for more information.

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

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

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

The following do not count toward the annual deductible:

- Copays for prescription drugs
- Copays paid under the Copay Plan with HRA and the Local Copay Plan with HRA
- Charges for services that are not covered under the plan
- Charges in excess of the eligible expense, including amounts in excess of the allowed amount, billed by out-of-network providers in accordance with federal law
- The reduction amount applied that resulted from the failure to follow the pre-service authorization procedures that would otherwise be payable for eligible covered health services
- Prescription drug copays and costs, in the following circumstances:
  - Charges for the difference in cost between a generic drug and a brand-name drug if a brand-name drug is selected when a generic is available
  - Out-of-network prescription drug charges for the difference in cost between the full cost and the Express Scripts discounted amount
- Manufacturer assistance for prescription drugs does not apply toward your deductible and out-of-pocket maximums. See the "Manufacturer assistance programs/out-of-pocket protection program" section on page 2-114 for more information

Annual out-of-pocket maximum

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

If you cover dependents, eligible expenses for all covered members accrue toward the applicable level of coverage annual out-of-pocket maximum. The out-of-pocket maximum is not required to be met by each covered member. The out-of-pocket maximum can be met by any combination of covered members or by an individual covered member. The in-network and out-of-network annual out-of-pocket maximums do not accumulate jointly. Therefore, charges for services in-network do not count toward your out-of-network annual out-of-pocket expenses and vice versa. However, for the Copay Plan with HRA, the Tier 1 and Tier 2 in-network charges that apply to the out-of pocket maximums do count toward each other (cross-accumulate). See the "Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum" section on page 2-17 for more information.

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

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

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

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

Individual out-of-pocket maximum

Under the individual out-of-pocket maximum, no one individual will be required to pay more than $9,450 in annual in-network,

out-of-pocket expenses before the plan begins to pay 100% of covered eligible expenses. This individual maximum applies when the annual out-of-pocket maximum for the elected level of coverage exceeds $9,450.

- For the HSA Plan and Flex HDHP, when the applicable level of coverage has an in-network annual out-of-pocket maximum higher than $9,450, no one individual will pay more than $9,450 in combined eligible covered in-network medical and prescription drug expenses for the in-network annual out-of-pocket maximum.
- For the HSA Plan Out of Area coverage when the applicable level of coverage has an annual out-of-pocket maximum higher than $9,450, no one individual will pay more than $9,450 in eligible covered medical expenses (received from in-network and out-of-network providers combined) combined with in-network prescription drug eligible expenses for the annual out-of-pocket maximum.

Coinsurance

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

The amount of coinsurance you are required to pay may vary depending on whether you receive services from an in-network provider or an out-of-network provider and which medical plan you are enrolled in. You must meet the annual deductible before the coinsurance applies for all services unless specifically noted otherwise in this SPD. See the "What the medical plans cover" section starting on page 2-43 and the "Prescription drug benefit" section starting on page 2-112.

Copay

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

Copays generally must be paid to the provider at the time you receive the service. See the cost-sharing tables starting on page 2-47, and the "Prescription drug benefit" section starting on page 2-112 for services subject to a copay. For the Copay Plan with HRA and the Local Copay Plan with HRA, you do not need to meet the annual deductible before the copay applies. But for the HSA Plan and Flex HDHP, you will need to meet the annual deductible before prescription drug copays apply unless your prescribed drug is on the preventive drug therapy list.

Plan year

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

How the Copay Plan with HRA and Local Copay Plan with HRA work

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

- You pay a copay for certain services (prescription drugs, office visits, convenience care in a retail setting, telemedicine, emergency room and urgent care). You do not need to meet the annual deductible before the copay applies. Copays don't count toward the annual deductible. See the cost-sharing tables starting on page 2-47 for more information on copays. Refer to the "Prescription drug benefit" section starting on page 2-112 for information about what you will pay for prescription drugs.
- You pay 100% of eligible expenses for non-copay covered health services until you satisfy the applicable annual deductible, except as otherwise noted in the cost-sharing tables starting on page 2-47, and in the "Prescription drug benefit" section starting on page 2-112. For more information on the applicable annual deductible, see the "Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum" section on page 2-17 and the "The Local Copay Plan with HRA: Annual deductible and annual out-of-pocket maximum" on page 2-18.
- After you satisfy the applicable annual deductible:
  - For the Copay Plan with HRA in-network and Out of Area coverage, you will typically pay coinsurance for your share of eligible expenses for most covered health services received.
    - Tier 1: 10% coinsurance
    - Tier 2: 20% coinsurance
  - For the Local Copay Plan with HRA in-network services, you will typically pay 10% coinsurance for your share of eligible expenses for most covered health services received outside of an office visit.
  - For the Copay Plan with HRA out-of-network services, you will typically pay 50% coinsurance for your share of eligible expenses for most covered health services. **Note:** There is no out-of-network coverage for the Local Copay Plan with HRA (except for emergency care).
  - For prescription drugs, under both the Copay Plan with HRA and Local Copay Plan with HRA you will pay the applicable prescription drug copay.

Refer to the "Services covered under the medical plans" section starting on page 2-46 and the corresponding cost-sharing tables starting on page 2-47 for more specific information on in-network, out-of-network, and Out of Area coverage cost-sharing percentages and other requirements for covered health services.

- Prescription drug copays apply regardless of whether or not you have met the annual deductible for medical services. Refer to the "Prescription drug benefit" section starting on page 2-112 for information about what you will pay for prescription drugs.
- For certain covered health services (or prescription drugs) not subject to the annual deductible, the applicable copay or coinsurance does not count toward the annual deductible, but it does count toward the annual out-of-pocket maximum.
- After you satisfy the applicable annual out-of-pocket maximum, the medical plan pays 100% of eligible expenses for covered health services (for example, if you have met the in-network annual out-of-pocket maximum, the plan will pay 100% of eligible covered expenses for covered health services from an in-network provider for the remainder of the year, but it would not pay 100% of eligible expenses for covered health services received from an out-of-network provider until the out-of-network annual out-of-pocket maximum has been met, except for covered emergency services).
- Additional information about services received from in-network providers:
  - The in-network provider should request any required pre-service authorizations for you. However, it's your responsibility to ensure that the necessary pre-service authorizations have been received before services are provided. For more information, see the "Pre-service authorization requirements" section starting on page 2-40.
  - The in-network provider will file claims for you.
  - You pay 100% for services and expenses not covered by the medical plan; however, you are generally not responsible for any charges the in-network provider must write off as a result of its contract with the claims administrator or the claims administrator's associated networks.

For more information on in-network providers, see the "Providers and provider networks" section starting on page 2-10.

- For the Copay Plan with HRA only, additional information about services received from out-of-network providers:
  - You must contact the claims administrator to receive required pre-service authorizations for certain services (see the "Pre-service authorization requirements" section starting on page 2-40) before receiving those services from an out-of-network provider.
  - You may be required to pay the out-of-network provider and file claims for reimbursement (see the "Claims and appeals" section starting on page 2-107 for more information). If the out-of-network provider files claims for you, you are responsible for ensuring the provider follows the plan's claims filing requirements, including filing a claim within 12 months from date of service.
  - In some situations, an out-of-network provider can bill you for all expenses the plan does not cover, including those above the eligible expense (or allowed amount), and you are responsible for payment to the out-of-network provider unless prohibited by federal law. The difference between the out-of-network provider's billed charges and the eligible expense (allowed amount) is generally not applied toward the annual deductible or annual out-of-pocket maximum and is your responsibility. This applies to all out-of-network services described in this SPD chapter, including Out of Area coverage.
- For both the Copay Plan with HRA and the Local Copay Plan with HRA, you pay:
  - 100% for expenses above those considered eligible expenses by the plan
  - 100% for services and expenses not covered by the plan

Prescription drug benefit

Express Scripts administers the prescription drug benefits offered under the:

- HSA Plan*
- Copay Plan with HRA*
- [illegible]
- Flex HDHP

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

[illegible]
Express Scripts' coverage criteria. In addition, all prescriptions are subject to the limitations, exclusions, and procedures described in this "Prescription drug benefit" section of the [illegible] drug benefit (even if other medications in the same therapeutic class are covered). To obtain information on the established criteria, or to find out if your drug is on the Express Scripts National Preferred Drug List (a listing of preferred drugs), is covered, or is subject to certain prescription drug benefit [illegible] express-scripts.com or call Express Scripts Member Services at 1-855-388-0352.

If you take an ongoing maintenance medication you are required [illegible] 90-day supply from Express Scripts Home Delivery or at a CVS or Walgreens retail pharmacy. For more information see the [illegible]

Filling your prescription

Where you fill your medication will depend on the type of [illegible]

Short-term medications

Short-term medications are generally those you take for less than 90 days. They may be antibiotics or a short-term [illegible]

You can fill up to a 30-day supply of your prescription at any [illegible] [illegible]
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 [illegible]

Maintenance medications

[illegible] ongoing basis for chronic, long-term conditions such as those used to control blood pressure. This excludes medications that cannot be prescribed in a 90-day supply for clinical reasons (such as certain controlled substances). This also excludes drugs your doctor prescribes for a short-term condition, such as antibiotics.

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

- When you get your 90-day supply of prescribed maintenance [illegible] prescriptions: Copay Plan with HRA and Local Copay Plan with [illegible]" table on page 2-116, or the "[illegible] prescriptions: HSA Plan and Flex HDHP" table on page 2-117).
- If you do not get your 90-day supply filled at one of the three options listed above, you will pay 100% of the cost of the [illegible] would normally be covered at 100%.
  - If you pay 100% of the cost, you will not be able to submit a [illegible] not apply to any deductible or out-of-pocket accumulators.

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

Specialty medications

Specialty medications are used to manage long-term (chronic), rare, and complex conditions or genetic disorders. These include, [illegible] immune deficiencies. The medications are often injectable or intravenously (IV) infused, but may also be taken orally or inhaled. [illegible] medications must be filled through Accredo, your specialty [illegible] page 2-119 for more information. Also, certain specialty drugs on [illegible] page 2-115 for more information.

manufacturer assistance). The adjustments will occur nightly, and you will receive a monthly notice of any applicable adjustments.

SaveOnSP Program

If you participate in the Copay Plan with HRA or Local Copay Plan with HRA and you take a specialty medication, you may be eligible for the SaveOnSP program administered by Express Scripts and SaveOnSP. With this program, you are eligible to receive specialty medications, if they are on the SaveOnSP drug list, at no cost as long as you are enrolled in the manufacturer copay assistance program and agree to participate in the SaveOnSP program. Please visit www.saveonsp.com/wellsfargo or call 1-800-683-1074 to see if your medication is included in the program and to view the cost share that will apply if you do not agree to participate in the program. If your medication is included on the SaveOnSP drug list and you do not agree to participate in the SaveOnSP program, you will be responsible for the full amount of the cost share for that medication as given on the SaveOnSP drug list. This amount will not be applied toward satisfying your out-of-pocket maximum.

Compound drugs

The copay for compound medications will be based on the amount submitted by the compounding pharmacy, or 150% of the average wholesale price, whichever is lower. Ingredients that are not covered under the plan provisions will not be covered as part of a compound. For example, over-the-counter products that are commonly included in compounds such as Benadryl, Maalox, Eucerin, and hydrocortisone that are not covered under the plan will not be covered in a compound.

The compounded formulation must be covered and, if it is reformulated, it must meet FDA-approved guidelines for the condition. Coverage is provided for compounds when they are used in accordance with FDA-approved indications, supported uses, and routes of administration found in medical compendia or other current accepted practice guidelines. All other plan provisions apply.

Note: In the HSA Plan and Flex HDHP, if your drug or supply is not on the preventive therapy drug list, you must meet the annual deductible before benefits are available.

Fertility solutions (including infertility) drugs

Fertility solution medications (including infertility) are covered up to a lifetime maximum benefit of $10,000. You will pay the applicable deductible or copay for the medication. The cost of the medication covered by the Plan applies to the lifetime maximum benefit. Most fertility solutions medications are subject to pre-service authorization requirements. For coverage under the plan up to the lifetime maximum benefit, you must purchase your fertility and infertility medications through Accredo/Freedom Fertility. (See the "Some prescriptions may require pre-service authorization, step therapy, or quantity limits" section on page 2-119 for more information.) Medications for donors and partners (for example, suppression medications or stimulation medications) for anyone not enrolled in the plan, including a donor, are not covered. To determine your accrued Lifetime maximum benefit, log into express-scripts.com and go to ***Benefit Plan Balances*** to determine balances. Or you can call Express Scripts and speak to a Patient Care Advocate and ask for balance.

National Preferred Drug List

Certain prescription drugs are included on the Express Scripts National Preferred Drug List. This list, sometimes called a formulary, includes a wide selection of generic and brand-name drugs. Express Scripts maintains the Express Scripts National Preferred Drug List, including ensuring that the list is reviewed and updated regularly by an independent pharmacy and therapeutics committee. The list is continually revised by Express Scripts to ensure that the most up-to-date information is taken into account. Go to express-scripts.com or call 1-855-388-0352 to see if your prescription is on the list.

Drug categories

The prescription drug benefit categorizes prescriptions as follows:

- **Generic prescription drugs.** Generic drugs generally cost less than therapeutically equivalent brand-name drugs.

  The Food and Drug Administration (FDA) ensures that generic drugs meet the same standards for safety and effectiveness as their brand-name equivalents.

  Most drugs that are no longer under patent protection may be available in a generic form from multiple manufacturers. Express Scripts determines which drugs are considered generic based on data from an industry standard independent third party. It is unusual, but possible, for a drug to be classified as a generic and then to be reclassified as a brand at a later time. If you are prescribed such a drug, contact your provider for treatment options.

- **Preferred brand-name drugs.** Brand-name prescription drugs that are on the National Preferred Drug List as determined by Express Scripts.

  These drugs may or may not have generic equivalents available.

- **Nonpreferred brand-name drugs.** Brand-name prescription drugs that are not on the National Preferred Drug List as determined by Express Scripts.

  You'll generally pay more for nonpreferred brand-name drugs covered under the plan.

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

Note: Biosimilars. A biosimilar product is a biological product that is approved based on a showing that it is highly similar to an already-approved biological product. The biosimilar also must show it has no clinically meaningful differences in terms of safety and effectiveness. Only minor differences in clinically inactive components are allowable in biosimilar products.

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

You do not pay a deductible for prescription drug costs and prescription drug copays do not count toward your medical annual deductible; however, copays do count toward your annual out-of-pocket maximum. See the "Important terms" section starting on page 2-14 for more information about the annual deductible and annual out-of-pocket maximum. See the "No cost-share preventive medications" section starting on page 2-114 for more information about certain preventive drugs covered at 100%.

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

Type of drug	In-network retail pharmacy (for short-term (acute) medication up to a 30-day supply)	Out-of-network retail pharmacy (for short-term (acute) medication up to a 30-day supply)	Express Scripts Home Delivery (for all covered medications up to a 90-day supply) **or CVS and Walgreens retail pharmacy** (for all covered medications 31- to 90-day supply)
Generic	You pay a $12 copay.[1, 2] **Note:** Generic contraceptives are covered at 100%.	You pay a $12 copay.[1, 2] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $24 copay.[1, 2] **Note:** Generic contraceptives are covered at 100%.
Preferred brand-name drugs	You pay a $50 copay.[1, 2, 3]	You pay a $50 copay.[1, 2, 3] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $100 copay.[1, 2, 3]
Nonpreferred brand-name drugs	You pay a $90 copay.[1, 2, 3]	You pay a $90 copay.[1, 2, 3] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $180 copay.[1, 2, 3]
Specialty medications (this includes infertility and fertility drugs)	Not covered.	Not covered.	Only covered through Accredo specialty pharmacy delivery. You pay the following for a 90-day supply[1,2,3,4,5]: ◦ $150 copay for generic ◦ $285 copay for preferred brand-name drugs ◦ $435 copay for nonpreferred brand-name drugs **Note:** The copay is prorated for a 30- or 60-day supply of specialty medication.

1. The deductible does not apply.
2. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum.
3. When you purchase a brand-name drug and a generic is available, you will pay the generic drug copay plus the difference in cost between the generic and brand-name drug.
4. Manufacturer assistance does not apply toward your deductible and out-of-pocket maximums. If you receive manufacturer assistance, your deductible and out-of-pocket maximums will be adjusted following receipt of your prescription to reflect the amount you paid out of pocket (excluding the manufacturer assistance).
5. If your medication is included in the SaveOnSP program, you are eligible to receive your medication for no cost. If your medication is included on the SaveOnSP drug list and you do not agree to participate in the SaveOnSP program, you will be responsible for the full amount of the cost share for that medication as given on the SaveOnSP drug list. This amount will not be applied toward satisfying your out-of-pocket maximum. Visit www.saveonsp.com/wellsfargo or call 1-800-683-1074 to see if your drug is included in the program.

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

You must satisfy your applicable annual deductible under the HSA Plan or Flex HDHP before you begin paying the copay amounts listed in the table below, unless your drug is on the preventive therapy drug list. If your prescribed drug is on the preventive therapy drug list, you pay the copay amounts listed in the table below regardless of whether you have met your annual deductible or not. The copay amounts do not count toward your annual deductible, but they do count toward your annual out-of-pocket maximum. Go to express-scripts.com or call Express Scripts at 1-855-388-0352 to see if your prescription is considered to be a preventive therapy drug. See the "Important terms" section starting on page 2-14 for more information about the annual deductible and annual out-of-pocket maximum. See the "No cost-share preventive medications" section starting on page 2-114 for more information about certain preventive drugs covered at 100%.

Type of drug	**In-network retail pharmacy** (for short-term (acute) medication up to a 30-day supply)	**Out-of-network retail pharmacy** (for short-term (acute) medication up to a 30-day supply)	**Express Scripts Home Delivery** (for all covered medications up to a 90-day supply) **or CVS and Walgreens** [redacted] (for all covered medications 31- to 90-day supply)
Medications on the preventive therapy drug list	You do not need to meet the deductible. You pay: • $12 copay for generic[1] **Note:** Generic contraceptives are covered at 100%. • $50 copay for preferred brand-name drugs[1, 2] • $90 copay for nonpreferred brand-name drugs[1, 2]	You do not need to meet the deductible. You pay: • $12 copay for generic[1] • $50 copay for preferred brand-name drugs[1, 2] • $90 copay for nonpreferred brand-name drugs[1, 2] You also pay the difference between the full cost and the Express Scripts discounted amount.	You do not need to meet the deductible. You pay: • $24 copay for generic[1] **Note:** Generic contraceptives are covered at 100%. • $100 copay for preferred brand-name drugs[1, 2] • $180 copay for nonpreferred brand-name drugs[1, 2]
Generic	You pay a $12 copay after you satisfy the deductible. **Note:** Generic contraceptives are covered at 100%.	You pay a $12 copay after you satisfy the deductible. You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $24 copay after you satisfy the deductible. **Note:** Generic contraceptives are covered at 100%.
Preferred brand-name drugs	You pay a $50 copay after you satisfy the deductible.[2]	You pay a $50 copay after you satisfy the deductible.[2] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $100 copay after you satisfy the deductible.[2]
Nonpreferred brand-name drugs	You pay a $90 copay after you satisfy the deductible.[2]	You pay a $90 copay after you satisfy the deductible.[2] You also pay the difference between the full cost and the Express Scripts discounted amount.	You pay a $180 copay after you satisfy the deductible.[2]

Type of drug	In-network retail pharmacy (for short-term (acute) medication up to a 30-day supply)	Out-of-network retail pharmacy (for short-term (acute) medication up to a 30-day supply)	Express Scripts Home Delivery (for all covered medications up to a 90-day supply) **or CVS and Walgreens retail pharmacy** (for all covered medications 31- to 90-day supply)
Specialty medications (this includes infertility and fertility drugs)	Not covered.	Not covered.	Only covered through Accredo specialty pharmacy delivery. You pay the following for a 90-day supply after you satisfy the deductible[3]: ◦ $150 copay for generic ◦ $285 copay for preferred brand-name drugs ◦ $435 copay for nonpreferred brand-name drugs **Note:** The copay is prorated for a 30- or 60-day supply of specialty medication.

1. The copay does not count toward the annual deductible; however, the copay does count toward the annual out-of-pocket maximum.
2. When you purchase a brand-name drug and a generic is available, you will pay the generic drug copay plus the difference in cost between the generic and brand-name drug.
3. Manufacturer assistance does not apply toward your deductible and out-of-pocket maximums. If you receive manufacturer assistance, your deductible and out-of-pocket maximums will be adjusted following receipt of your prescription to reflect the amount you paid out of pocket (excluding the manufacturer assistance).

Preventive therapy drug list

Preventive medications are those generally prescribed to people who may be at risk for certain diseases or conditions and are not used to treat an existing illness or condition, even if the drug may prevent the illness or condition from progressing.
The preventive therapy drug list reflects guidance provided by the U.S. Department of Treasury indicating that certain drugs could be covered as preventive for selected conditions under a High-Deductible Health Plan (HDHP). The preventive therapy drug list is subject to change.

Go to express-scripts.com or call Express Scripts Member Services at 1-855-388-0352 to see if your prescription is considered to be a preventive therapy drug. See the "No cost-share preventive medications" section starting on page 2-114 for information about certain preventive drugs covered at 100%.

Additional prescription drug coverage provisions

The following provisions also apply to all prescription drug claims processing:

- In some cases, the full cost of a drug may be less than the copay, if applicable. In those cases, you will pay the lower amount.
- It's standard practice in most pharmacies (and, in some states, a legal requirement) to substitute generic equivalents for brand-name drugs whenever possible.
- If a biosimilar drug is available, you may be required to try a biosimilar before a brand-name reference product will be covered.
- Generic and some single-source brand-name contraceptives, filled at an in-network retail pharmacy, are covered at 100%. For more information on what's covered at 100%, contact Express Scripts Member Services at 1-855-388-0352. If there is a clinical reason that you cannot take a generic contraceptive, your doctor can submit a request to Express Scripts for review. If the request is approved, your brand-name contraceptive will be covered at 100%. Your doctor must submit a request for pre-service authorization review electronically. Information about electronic options can be found at express-scripts.com/PA. For questions about the pre-service authorization process, call 1-855-388-0352.
- If you purchase a brand-name drug when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand-name drug and the generic drug. The difference in cost between the brand-name drug and the generic drug will be calculated using the full cost of the brand-name drug before any associated rebate is applied to reduce the cost of the brand-name drug. The full cost of the brand-name drug before application of any associated rebate may be higher than the cost of the brand-name drug as disclosed by Express Scripts' pricing tools and cost estimates. Any difference in cost between the brand-name and generic is not applied to any applicable deductible, maximum per prescription amount, or to any out-of-pocket maximum listed above. If there is a clinical reason that you cannot take a generic drug, your doctor can submit a request to Express Scripts for review. If the request is approved, you will pay the applicable nonpreferred brand-name drug cost amount listed

This list is subject to change. To determine if your prescription is covered, visit express-scripts.com or contact Express Scripts Member Services at 1-855-388-0352.

Prescription drug coordination of benefits

The prescription drug benefit does not coordinate with other plans, including Medicare or Medicare Part D. This prescription drug benefit provides primary payment only and does not issue detailed receipts for submission to other carriers for secondary coverage. If another insurance company, plan, or program pays your prescription benefit first, there will be no payments made under this plan. Because there is no coordination of benefits provision for prescription drugs, you cannot submit claims to Express Scripts for reimbursement after any other payer has paid primary or has made the initial payment for the covered drugs.

If you or a covered dependent is covered under either the HSA Plan, the Copay Plan with HRA, the Local Copay Plan with HRA, or the Flex HDHP and Medicaid or other similar state programs for prescription drugs, in most instances, your prescription drug coverage under your medical plan at Wells Fargo is your primary drug coverage. You should purchase your prescription drugs using your Express Scripts ID card and submit out-of-pocket copay expenses to Medicaid or other similar state programs.

Prescription drug claims and appeals

Express Scripts is the named claims and appeals fiduciary for the prescription drug claims and has sole and complete discretionary authority to determine the applicable claims and appeals in accordance with the terms of the documents or instruments governing the prescription drug benefits under the medical plans.

Filing a prescription drug claim

Urgent care claims

If the prescription drug benefit requires pre-service authorization to receive benefits and a faster decision is required to avoid seriously jeopardizing the life or health of the claimant, your physician must make the urgent care claim request by calling 1-800-753-2851. If you have questions, call Express Scripts Member Services at 1-855-388-0352.

Important: Specifically state that your request is an urgent care claim.

Pre-service claims

If the prescription drug benefit requires pre-service authorization to receive benefits but is not considered an urgent care claim, your physician must submit the request for review electronically. Information about electronic options can be found at express-scripts.com/PA. For questions about the pre-service authorization process, call 1-855-388-0352.

Post-service claims

You will need to file a claim if you buy prescription drugs or other covered supplies from a pharmacy not in the Express Scripts network or if the in-network pharmacy was unable to submit the claim successfully. All claims must be received by Express Scripts within 12 months from the date the prescription drug or covered supplies were dispensed. Claims not submitted within 12 months from the date the prescription drug or covered supplies were dispensed will not be covered.

Your out-of-network claim will be processed faster if you follow the correct procedures. Complete the Prescription Drug Reimbursement form and send it with the original prescription receipts. You may not use cash register receipts or container labels from prescription drugs purchased at an out-of-network pharmacy.

Prescription drug bills must provide the following information:

- Patient's full name
- Prescription number and name of medication
- Charge and date for each item purchased
- Quantity of medication
- Doctor's name

To get a claim form:

- Go to express-scripts.com, sign in, and download the claim form.
- Call Express Scripts Member Services at 1-855-388-0352 to request a form.

Send your claim to:

Express Scripts
Attn: Benefit Coverage Review Department
PO Box 66587
St. Louis, MO 63166-6587
Fax: 1-877-328-9660

You are responsible for any charges incurred but not covered.

Refer to "Appendix A: Claims and Appeals." for more information regarding claims.

Express Scripts claims questions, denied coverage, and appeals

If you have a question or concern about a claim already filed with Express Scripts, you may contact Express Scripts Member Services at 1-855-388-0352.

In the event your claim is denied (in whole or in part), you may also file a formal appeal under the terms of the Health Plan. A formal written appeal must be filed with Express Scripts within 180 days from the date you receive notification that your claim is denied, regardless of any verbal discussions that have occurred regarding your claim. (Exception: Urgent care claim appeals may be requested verbally.) Once you exhaust the internal appeals procedures, you may be entitled to an external review of your claim.

Complete information on appeals is provided in "Appendix A: Claims and Appeals."

Appendix B: Important Notifications and Disclosures

Contents

Plan information

Employer identification number

The IRS has assigned the employer identification number (EIN) 41-0449260 to Wells Fargo & Company. Use this number if you correspond with the government about the Wells Fargo-sponsored plans. In addition, Wells Fargo & Company has assigned a three-digit plan identification number to each plan. The "ERISA plans sponsored by Wells Fargo" table starting on page B-7 shows each plan's official name, the type of plan, the plan's number, and the phone number of any claims administrator, HMO, or insurer.

Plan sponsor

Wells Fargo & Company is the plan sponsor for all of the plans listed in the "ERISA plans sponsored by Wells Fargo" table starting on page B-7. Please use the address below for any correspondence to the plan sponsor and include the plan name and plan number in your correspondence:

Wells Fargo & Company
MAC A0101-121
420 Montgomery St.
San Francisco, CA 94104

Plan administrator

The plan administrator for all plans listed in the "ERISA plans sponsored by Wells Fargo" table starting on page B-7, for purposes of ERISA §3(16)(A), is Wells Fargo & Company's: Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), and Head of Benefits (or the functional equivalent title of the most senior position in Human Resources over benefit plans and programs other than the Head of Human Resources and Head of Total Rewards), each of whom, acting individually or jointly, may take action as the plan administrator, or its or their authorized delegate. The plan administrator has full discretionary authority to administer and interpret those plans. The plan administrator may delegate duties and authority to others to accomplish those duties.

The plan administrator's address is:

Plan Administrator
Wells Fargo & Company
MAC N9310-110
550 S. 4th St.
Minneapolis, MN 55415

You may also contact Employee Care by accessing chat, submitting an inquiry through HR Services & Support, or by phone at 1-877-HRWELLS (1-877-479-3557), option 2

The insurer of each "insured" ERISA plan sponsored by Wells Fargo & Company has sole and complete discretionary authority to administer and interpret the provisions of the plan it insures. Please see the "ERISA plans sponsored by Wells Fargo" table starting on page B-7 to determine whether a plan is insured and for corresponding contact information for the applicable insurer or claims administrator.

Agent for service

Wells Fargo & Company's Corporate Secretary, at the address below, is the designated agent for service of legal process for the plans. You can also serve legal process on the plan administrator at the address listed above.

Corporate Secretary
Wells Fargo & Company
30 Hudson Yards
Floor 61
New York, NY 10001-2170

For information about service for legal process upon a plan's HMO, insurer, or claims administrator, contact the HMO, insurer, or claims administrator as noted in the "ERISA plans sponsored by Wells Fargo" table starting on page B-7.

No legal action can be taken against any party with regard to a claim for benefits under the plans until the applicable claims and appeals procedures described in this *Benefits Book* have been exhausted. Any suit for benefits must be brought within one year of the date of the final appeal determination (or deemed final determination) or three years from the date the service or treatment was provided, whichever is earlier, unless otherwise noted in the applicable chapter of this *Benefits Book*.

No legal action can be taken against any party with regard to a dispute of eligibility or enrollment until the process described in "Enrollment and eligibility disputes" has been completed, as detailed in "Chapter 1: Eligibility, Enrollment, and More." Any legal action must be brought within one year of the date of the final determination issued by Corporate Benefits on behalf of the plan administrator.

Plan trustee

The plan trustee for the Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents) and the Wells Fargo & Company Short-Term Disability Plan is:

Delaware Charter Guarantee & Trust Company
d/b/a Principal Trust Company
1013 Centre Road, Suite 300
Wilmington, DE 19805-1265

Plan year

Financial records for the plans are kept on a calendar year basis, also known as the "plan year," beginning on January 1 and ending the following December 31.

Disclosure about health savings accounts

Wells Fargo & Company sponsors and maintains high-deductible health plans for plan participants and their eligible dependents that are compatible with a health savings account ("HSA"). However, the HSA itself is not part of any ERISA-covered employee benefit plan sponsored or maintained by Wells Fargo & Company or any of its subsidiaries or affiliates.

Further, it is Wells Fargo & Company's intention to comply with the U.S. Department of Labor issued guidance, which specifies that an HSA is not subject to ERISA when the employer's involvement is limited. Establishment of an HSA is completely voluntary on your part.

- Wells Fargo & Company does not limit your ability to move your funds to another HSA or impose conditions on usage of HSA funds beyond those permitted under the Internal Revenue Code. However, Wells Fargo & Company will only support payroll deductions or provide funding of health and wellness dollars and other employer contributions, if applicable, for HSAs opened through Wells Fargo's HSA vendor, Optum Bank.
- Wells Fargo & Company does not make or influence the investment decisions with respect to funds contributed to an HSA. Available HSA investment funds are not guaranteed and you could lose money.
- Wells Fargo & Company does not represent that the HSA is an ERISA-covered employee benefit plan established or maintained by Wells Fargo & Company or any of its subsidiaries or affiliates.

A health savings account is an individually owned account. The health savings account will continue to be your account, even if you leave Wells Fargo or change health plan coverage.

Participating employers

The plans generally cover employees of Wells Fargo & Company and those subsidiaries and affiliates of Wells Fargo & Company that have been authorized to participate in the plans. These participating Wells Fargo companies are called participating employers. Participants and beneficiaries in the plans may receive, on written request, information as to whether a particular subsidiary or affiliate is a participating employer of a particular plan, and if it is, the participating employer's address. To request a complete list of participating employers in the plans, write to the applicable plan administrator.

For the address of the plan administrator for the plans covered in this *Benefits Book*, see the "Plan administrator" section starting on page B-5.

Future of the plans

Wells Fargo & Company reserves the unilateral right to amend, modify, or terminate any of its benefit plans (or benefit plan options), programs, policies, or practices at any time, for any reason, with or without notice. Any such amendment, modification, or termination may apply to both current and future participants and their dependents and beneficiaries.

Plan amendments

Wells Fargo & Company, by action of its Board of Directors, the Human Resources Committee of the Board of Directors, or that of a person so authorized by resolution of the Board of Directors or the Human Resources Committee, may amend the plans at any time, for any reason, with or without notice. In addition, Wells Fargo & Company's: Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), or their delegate may amend the plans to comply with changes in applicable law, add or amend exhibits to the plans, or make changes in the administration or operation of the plans (subject to any limitations specified in the applicable resolutions adopted by the Board of Directors of the Company).

Plan termination

Wells Fargo & Company may terminate any plan at any time, for any reason, with or without notice by action of Wells Fargo's Board of Directors. Wells Fargo & Company, by written action of its President, Chief Executive Officer, Head of Human Resources (or the functional equivalent title of the most senior position in Human Resources), Head of Total Rewards (or the functional equivalent title of the most senior position in Human Resources over compensation and benefit plans or programs other than the Head of Human Resources), or their delegate (subject to any limitations specified in applicable resolutions adopted by the Board of Directors of the Company), may terminate any plan at any time, for any reason, with or without notice, as it applies to any participating employer.

ERISA plans sponsored by Wells Fargo

Plan name	Plan coverage option	Plan number	Service provider or insurer
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	Copay Plan with Health Reimbursement Account (HRA)* (Self-insured[2]) * Including Out of Area Coverage	537	**Medical** UnitedHealthcare 1-800-842-9722 **Prescriptions** Express Scripts 1-855-388-0352 **HRA claims** HealthEquity 1-877-924-3967
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	Health Savings Account (HSA) Plan*,[3] (Self-insured[2]) * Including Out of Area Coverage	537	**Medical** Anthem Blue Cross Blue Shield 1-866-418-7749 UnitedHealthcare 1-800-842-9722 **Prescriptions** Express Scripts 1-855-388-0352
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	Local Copay Plan with Health Reimbursement Account (HRA) (Self-insured[2])	537	**Medical** Anthem Blue Cross Blue Shield 1-866-418-7749 Centivo 1-833-666-1506 UnitedHealthcare 1-800-842-9722 **Prescriptions** Express Scripts 1-855-388-0352
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	Flexible High-Deductible Health Plan (Self-insured[2])	537	**Medical** Anthem Blue Cross Blue Shield 1-866-418-7749 UnitedHealthcare 1-800-842-9722 **Prescriptions** Express Scripts 1-855-388-0352
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser California (Insured[4]) (Northern and Southern California)	537	Kaiser Permanente 1-800-464-4000
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser Colorado (Insured[4])	537	Kaiser Permanente 1-800-632-9700
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	POS Kaiser Added Choice — Hawaii (Insured[4])	537	Kaiser Hawaii 1-800-966-5955
Wells Fargo & Company Health Plan (for Eligible Active Employees and Their Dependents)[1]	HMO — Kaiser Mid-Atlantic (Insured[4])	537	Kaiser Permanente D.C. area 301-468-6000 Outside D.C. area 1-800-777-7902

1. This plan will be known as the Wells Fargo & Company Health Plan (or the Health Plan) throughout this *Benefits Book*.
2. "Self-insured" means benefits are paid for by the plan through a trust. The identified service provider provides claims administrative services and is the claims and appeals fiduciary.
3. Your individual HSA is not part of the ERISA plan and is not sponsored by Wells Fargo. See "Appendix C: Health Savings Accounts" for more information about your HSA.
4. "Insured" means benefits are fully insured and paid for by the insurer, which may be an HMO.

EXHIBIT C

Fingolimod 0.5 Mg Capsule

Pharmacy: Delivery

Days supply: 30

Quantity: 90

Total medication cost:	**$ 3,331.46**
Plan pays*:	**$ 3,281.46**
You pay:	**$ 50.00**
Applied to your out-of-pocket:	**$ 50.00**
Cost per day:	**$ 1.67**

Your plan pays about 98% of the cost for this medicine.

*The cost to your plan does not include any rebates or other incentives your plan may receive from your use of this medication. Express Scripts may retain or share some rebates with your plan. The cost your plan pays is an approximation and is subject to change.