The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, employees visit Benefits on Teamworks or access teamworks.wellsfargo.com; or call 1-877-479-3557. COBRA participants visit https://cobra.ehr.com or call 1-877-292-6272. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or request a copy by calling 1-877-479-3557 (employees) or 1-877-292-6272 (COBRA).

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Coverage Level / In-network (or Out of Area* coverage) / Out-of-network You: $1,000 / $4,000 You + spouse/partner: $1,600 / $6,400 You + children: $1,350 / $5,400 You + spouse/partner + children: $1,900 / $7,600 If you have HRA dollars available, they can help cover the cost of the deductible. * Out of Area coverage only available if you do not live in network area	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Eligible preventive care, in-network (or Out of Area coverage): PCP and outpatient mental health office visit charge, specialist office visit charge, urgent care visit charge, telemedicine/virtual visit charge at certain in-network providers, and retail convenience care visit charge; and prescription drug costs are not subject to the deductible and don't count toward the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Coverage Level / In-network (or Out of Area* coverage) / Out-of-network You: $3,500 / $10,000 You + spouse/partner: $5,600 / $16,800 You + children: $4,550 / $14,400 You + spouse/partner + children: $6,650 / $19,200 *Out of Area coverage only available if you do not live in network area.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-service authorization, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Generally, yes. Contact your claims administrator for a list of network providers. • For Aetna visit, Aetna.com or call 1-877-320-4577 • For Anthem BCBS, visit anthem.com or call 1-866-418-7749 • For UnitedHealthcare, visit myuhc.com or call 1-800-842-9722	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-network Provider or Out of Area coverage (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	• $25 office visit copay • 20% coinsurance all other charges (even if related to office visit)	50% coinsurance	Deductible doesn't apply to copay for office visit charge only. Copay doesn't count toward deductible. Deductible and coinsurance apply to all other in-network charges and all out-of-network charges.
	Specialist visit	• $45 office visit copay • 20% coinsurance all other charges (even if related to office visit)	50% coinsurance	• Deductible doesn't apply to copay for office visit charge only. Copay doesn't count toward deductible. Deductible and coinsurance apply to all other in-network charges and all out-of-network charges. • Infertility/fertility: pre-service authorization required, $25,000 lifetime max for medical services and $10,000 lifetime max for related prescriptions • Chiropractic*: 26-visit limit annually • Acupuncture*: 26-visit limit annually • Therapies* (all physical, occupational, and speech combined): 90-visit limit annually * $25 office visit copay applies

* For more information about limitations and exceptions, see the summary plan description at teamworks.wellsfargo.com; or for COBRA at https://cobra.ehr.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-network Provider or Out of Area coverage (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Preventive care/ screening/immunization	No charge	50% coinsurance	Deductible doesn't apply. Category also includes women's preventive health care services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	• If more than one test is performed within the same diagnostic family during the same session, the first eligible procedure is considered at 100% of allowed amount; all other procedures may be considered at a reduced amount • Pre-service authorization required for imaging services
	Imaging (CT/ PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at express-scripts.com	Generic drugs	• $10 copay per retail prescription • $20 copay per Express Scripts Home Delivery (mail order) prescription	• $10 copay per retail prescription • Mail order – no coverage	• Deductible doesn't apply to copay. Copay doesn't count toward deductible. • Retail: covers up to a 30-day supply; CVS/Pharmacy store also covers 31- to 90-day supply for Express Scripts Home Delivery copay • Out-of-network retail: you pay copay plus difference between full cost and the Express Scripts discounted amount • In-network Express Scripts Home Delivery: 31- to 90-day supply • Generic and single-source brand name contraceptives in-network coverage: 100% • Pre-service authorization required for some medications 1. Certain insulins may be available for a $25 copay/30-day supply or $75 copay/90-day supply through the Express Scripts Patient Assurance Program. 2. If generic is available, you pay generic copay plus cost difference between generic and brand drug, does not apply to deductible or out-of-pocket limit.
	Preferred brand drugs	• $45 copay[1, 2] per retail prescription • $90 copay[1, 2] per Express Scripts Home Delivery (mail order) prescription	• $45 copay[2] per retail prescription • Mail order – no coverage	
	Non-preferred brand drugs	• $75 copay[2] per retail prescription • $150 copay[2] per Express Scripts Home Delivery (mail order) prescription	• $75 copay[2] per retail prescription • Mail order – no coverage	
	Specialty drugs	Only covered through Accredo Specialty Pharmacy $150 copay for a 90-day supply (copay is prorated for 30- or 60-day supply)	Not covered	To obtain specialty drugs, you must call Accredo Specialty Pharmacy at 1-800-803-2523 • Pre-service authorization required • Deductible doesn't apply to copay. Copay doesn't count toward deductible.

* For more information about limitations and exceptions, see the summary plan description at teamworks.wellsfargo.com; or for COBRA at https://cobra.ehr.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-network Provider or Out of Area coverage (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	• If more than one surgical procedure, all other procedures considered at 50% of allowed amount. • Out-of-network asst. surgeon fees considered as percentage of allowed amount for primary surgeon. • If surgery is performed in the physician's office and you are billed for an office visit, you will also pay the applicable office visit copay.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies
	Emergency medical transportation	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies
	Urgent care	$45 copay	50% coinsurance	• Convenience care in retail setting (such as, Minute Clinic) – in-network $25 copay. • Deductible doesn't apply to copay. Copay doesn't count toward deductible. Deductible and coinsurance apply to all other charges (for example, lab work) related to convenience care or urgent care visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	• Pre-service authorization required; out-of-network services 20% noncompliance penalty. • If more than one surgical procedure, all other procedures are considered at 50% of allowed amount. • Out-of-network asst. surgeon fees considered as percentage of allowed amount for primary surgeon. • For eligible spine and joint procedures, completion of treatment decision support and use of a designated facility covered 100% after deductible. No out-of-network coverage.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the summary plan description at teamworks.wellsfargo.com; or for COBRA at https://cobra.ehr.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-network Provider or Out of Area coverage (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	• $25 office visit copay • 20% coinsurance all other charges (even if related to office visit)	50% coinsurance	Deductible doesn't apply to copay for office visit charge only. Copay doesn't count toward deductible. Deductible and coinsurance apply to all other in-network charges and all out-of-network charges.
	Inpatient services	20% coinsurance	50% coinsurance	Pre-service authorization required: out-of-network services 20% noncompliance penalty
If you are pregnant	Office visits	• $25 copay PCP or OB/GYN office visit • $45 copay specialist office visit • 20% coinsurance all other charges (even if related to office visit)	50% coinsurance	Deductible doesn't apply to copay for office visit charge only. Copay doesn't count toward deductible. Deductible and coinsurance apply to all other in-network charges and all out-of-network charges. Maternity care may include tests and services described elsewhere in the SBC (such as ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	• Pre-service authorization required for hospital stay greater than 48 hours for vaginal delivery, 96 hours for Cesarean delivery; out-of-network services 20% noncompliance penalty • Global bill: claims processing varies, see the "Maternity care" section in Chapter 2: Medical Plans of the *Benefits Book* • The baby's charges are covered only if the child is added to your coverage through Wells Fargo within 60 days from the date of birth
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the summary plan description at teamworks.wellsfargo.com; or for COBRA at https://cobra.ehr.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-network Provider or Out of Area coverage (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	• 100-visit limit annually combined with extended skilled nursing care services • Pre-service authorization required; out-of-network services 20% noncompliance penalty
	Rehabilitation services	• $25 copay PCP office visit • $45 copay specialist office visit • 20% coinsurance all other charges (even if related to office visit)	50% coinsurance	• Deductible doesn't apply to copay for office visit charge only. Copay doesn't count toward deductible. Deductible applies to all other in-network charges and all out-of-network charges • 90-visit limit annually: combined physical, occupational, and speech therapy, rehabilitation and habilitation services combined • Habilitation services are only covered for children up to their 18th birthday
	Habilitation services			
	Skilled nursing care	20% coinsurance	50% coinsurance	• 100-day limit annually in a skilled nursing facility • Extended skilled nursing care – 100-visit limit annually combined with home health care • Pre-service authorization required
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-service authorization required for single item costing $1,000 or more: out-of-network services 20% noncompliance penalty
	Hospice services	20% coinsurance	50% coinsurance	Pre-service authorization required
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Routine vision screenings as part of well child care may be covered – see preventive care services
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

* For more information about limitations and exceptions, see the summary plan description at teamworks.wellsfargo.com; or for COBRA at https://cobra.ehr.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (adult)
- Dental care (children)
- Glasses
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Out-of-network mail order prescriptions
- Out-of-network specialty drugs
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, covered only for pain therapy or treatment of nausea related to chemotherapy, pregnancy, or post-operative, 26-visit limit annually.
- Bariatric surgery, with pre-service authorization.
- Chiropractic care, 26-visit limit annually. (Not covered: treatment for asthma, allergies, recreational therapy, educational therapy, or self-care training; and care when measurable improvement has ceased.)
- Hearing aids, coverage is limited to once every 3 years. (Bone-anchored hearing aids are only covered per claims administrator's medical policy.) Batteries are not covered.
- Infertility treatment, pre-service authorization required, coverage is limited to $25,000 lifetime benefit combined with any other infertility- or fertility-related medical services, plus $10,000 lifetime maximum for related prescription drugs.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: BenefitConnect™ | COBRA at 1-877-292-6272 or https://cobra.ehr.com, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the claims administrator on your ID card or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al – Employees: 1-877-479-3557; COBRA participants: 1-877-292-6272.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 – Employees: 1-877-479-3557; COBRA participants: 1-877-292-6272.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' – Employees: 1-877-479-3557; COBRA participants: 1-877-292-6272.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section

* For more information about limitations and exceptions, see the summary plan description at teamworks.wellsfargo.com; or for COBRA at https://cobra.ehr.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$ 1,000
Specialist copay	$ 45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$ 1,000
Copayments	$ 10
Coinsurance	$ 2,300
What isn't covered	
Limits or exclusions	$ 60
The total Peg would pay is	**$ 3,370**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$ 1,000
Specialist copay	$ 45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$ 900
Copayments	$ 700
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$ 20
The total Joe would pay is	**$1,620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$ 1,000
Specialist copay	$ 45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$ 200
Coinsurance	$ 200
What isn't covered	
Limits or exclusions	$ 0
The total Mia would pay is	**$1,400**

The plan would be responsible for the other costs of these EXAMPLE covered services.