



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:															
<p>What is the overall deductible?</p>	<table border="1"> <thead> <tr> <th data-bbox="436 456 730 492">Coverage</th> <th data-bbox="730 456 1045 492">In-network (or Out of Area* coverage)</th> <th data-bbox="1045 456 1232 492">Out-of-network</th> </tr> </thead> <tbody> <tr> <td data-bbox="436 542 730 578">You</td> <td data-bbox="730 542 1045 578">\$3,000</td> <td data-bbox="1045 542 1232 578">\$ 6,000</td> </tr> <tr> <td data-bbox="436 578 730 613">You + spouse/partner</td> <td data-bbox="730 578 1045 613">\$4,800</td> <td data-bbox="1045 578 1232 613">\$ 9,600</td> </tr> <tr> <td data-bbox="436 613 730 649">You + children</td> <td data-bbox="730 613 1045 649">\$3,900</td> <td data-bbox="1045 613 1232 649">\$ 7,800</td> </tr> <tr> <td data-bbox="436 649 730 727">You + spouse/partner + children</td> <td data-bbox="730 649 1045 727">\$5,700</td> <td data-bbox="1045 649 1232 727">\$11,400</td> </tr> </tbody> </table> <p>* Out of Area coverage only available if you do not live in network area</p>	Coverage	In-network (or Out of Area* coverage)	Out-of-network	You	\$3,000	\$ 6,000	You + spouse/partner	\$4,800	\$ 9,600	You + children	\$3,900	\$ 7,800	You + spouse/partner + children	\$5,700	\$11,400	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p>
Coverage	In-network (or Out of Area* coverage)	Out-of-network															
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<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Eligible preventive care and drugs on the eligible preventive drug therapy list.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/</p>															
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>															
<p>What is the out-of-pocket limit for this plan?</p>	<table border="1"> <thead> <tr> <th data-bbox="436 1101 730 1136">Coverage</th> <th data-bbox="730 1101 1045 1136">In-network (or Out of Area¹ coverage)</th> <th data-bbox="1045 1101 1232 1136">Out-of-network</th> </tr> </thead> <tbody> <tr> <td data-bbox="436 1187 730 1222">You</td> <td data-bbox="730 1187 1045 1222">\$5,250</td> <td data-bbox="1045 1187 1232 1222">\$10,500</td> </tr> <tr> <td data-bbox="436 1222 730 1258">You + spouse/partner</td> <td data-bbox="730 1222 1045 1258">\$8,400</td> <td data-bbox="1045 1222 1232 1258">\$16,800</td> </tr> <tr> <td data-bbox="436 1258 730 1294">You + children</td> <td data-bbox="730 1258 1045 1294">\$6,825</td> <td data-bbox="1045 1258 1232 1294">\$13,650</td> </tr> <tr> <td data-bbox="436 1294 730 1372">You + spouse/partner + children</td> <td data-bbox="730 1294 1045 1372">\$9,975²</td> <td data-bbox="1045 1294 1232 1372">\$19,950</td> </tr> </tbody> </table> <p>1. Out of Area coverage only available if you do not live in network area. 2. No one individual will need to incur more than \$8,700 in in-network out-of-pocket eligible expenses (for Out of Area¹ coverage, \$8,700 in in-network and out-of-network eligible expenses combined).</p>	Coverage	In-network (or Out of Area ¹ coverage)	Out-of-network	You	\$5,250	\$10,500	You + spouse/partner	\$8,400	\$16,800	You + children	\$6,825	\$13,650	You + spouse/partner + children	\$9,975 ²	\$19,950	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, the overall family <u>out-of-pocket limit</u> is the most you could pay in a year for covered service.</p>
Coverage	In-network (or Out of Area ¹ coverage)	Out-of-network															
You	\$5,250	\$10,500															
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What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-service authorization, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Generally, yes. Contact your claims administrator for a list of network providers. <ul style="list-style-type: none"> • 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 <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware that your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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	20% coinsurance	50% coinsurance	None
	<u>Specialist</u> visit	20% coinsurance	50% coinsurance	<ul style="list-style-type: none"> • 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
	<u>Preventive care/ screening/immunization</u>	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	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	50% coinsurance	<ul style="list-style-type: none"> • 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	

* 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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at express-scripts.com</p>	Generic drugs	<ul style="list-style-type: none"> \$10 copay per retail prescription \$20 copay per Express Scripts Home Delivery (mail order) prescription 	<ul style="list-style-type: none"> \$10 copay per retail prescription Mail order – not covered 	<ul style="list-style-type: none"> You must satisfy your annual deductible before the copays apply. The deductible doesn't apply to prescription drugs on the preventive drug therapy list. Copays for drugs on the preventive drug therapy list don't count toward the 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 the 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 based on cost of generic plus cost difference between generic and brand drug, does not apply to deductible or out-of-pocket limit.
	Preferred brand drugs	<ul style="list-style-type: none"> \$45 copay^{1,2} per retail prescription \$90 copay^{1,2} per Express Scripts Home Delivery (mail order) prescription 	<ul style="list-style-type: none"> \$45 copay² per retail prescription Mail order – not covered 	
	Non-preferred brand drugs	<ul style="list-style-type: none"> \$75 copay² per retail prescription \$150 copay² per Express Scripts Home Delivery (mail order) prescription 	<ul style="list-style-type: none"> \$75 copay² per retail prescription Mail order – not covered 	
	<u>Specialty drugs</u>	Only covered through Accredo Specialty Pharmacy \$150 copay for a 90-day supply (copay is prorated for 30- or 60-day supply)	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	<ul style="list-style-type: none"> 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.
	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 immediate medical attention	<u>Emergency room care</u>	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies
	<u>Emergency medical transportation</u>	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies
	<u>Urgent care</u>	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	<ul style="list-style-type: none"> • 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	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Pre-service authorization required; out-of-network services 20% noncompliance penalty
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (such as ultrasound). <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	<ul style="list-style-type: none"> • 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 <i>Benefits Book</i> • 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	<u>Home health care</u>	20% coinsurance	50% coinsurance	<ul style="list-style-type: none"> • 100-visit limit annually combined with extended skilled nursing care services • Pre-service authorization required; out-of-network services 20% noncompliance penalty
	<u>Rehabilitation services</u>	20% coinsurance	50% coinsurance	<ul style="list-style-type: none"> • 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
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	20% coinsurance	50% coinsurance	<ul style="list-style-type: none"> • 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
	<u>Durable medical equipment</u>	20% coinsurance	50% coinsurance	Pre-service authorization required for single item costing \$1,000 or more; out-of-network services 20% noncompliance penalty
	<u>Hospice services</u>	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 | • Long-term care | • Out-of-network specialty drugs |
| • Dental care (adult) | • Non-emergency care when travelling outside the U.S. | • Routine eye care (adult) |
| • Dental care (children) | • Private-duty nursing | • Routine foot care |
| • Glasses | • Out-of-network mail order prescriptions | • 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. | • 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. |
| • Bariatric surgery, with pre-service authorization. | • Infertility/fertility 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. |
| • 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.) | |

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, kwijijigo 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

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** \$ 3,000
- **Specialist coinsurance** 20%
- **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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$ 3,000
<u>Copayments</u>	\$ 10
<u>Coinsurance</u>	\$ 1,900
<i>What isn't covered</i>	
Limits or exclusions	\$ 60
The total Peg would pay is	\$ 4,970

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

- **The plan's overall deductible** \$3,000
- **Specialist coinsurance** 20%
- **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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,300
<u>Copayments</u>	\$ 300
<u>Coinsurance</u>	\$ 0
<i>What isn't covered</i>	
Limits or exclusions	\$ 20
The total Joe would pay is	\$2,620

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

- **The plan's overall deductible** \$3,000
- **Specialist coinsurance** 20%
- **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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$ 0
<u>Coinsurance</u>	\$ 0
<i>What isn't covered</i>	
Limits or exclusions	\$ 0
The total Mia would pay is	\$2,800

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