



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](https://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:  |
|---|--|-------------------|-----------------------|--|
| <b>What is the overall <u>deductible</u>?</b>                             | <u>Coverage</u>  | <u>In-network</u> | <u>Out-of-network</u> | 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.  |
|   | You  | \$ 500            | Not covered           |  |
|   | You + spouse/partner   | \$ 800            | Not covered           |  |
|   | You + children   | \$ 700            | Not covered           |  |
|   | You + spouse/partner<br>+ children   | \$1,000           | Not covered           |  |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Eligible preventive care, in-network: 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 <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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.  |                   |                       | You don't have to meet <u>deductibles</u> for specific services.   |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | <u>Coverage</u>  | <u>In-network</u> | <u>Out-of-network</u> | 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 services.  |
|   | You  | \$3,000           | Not covered           |  |
|   | You + spouse/partner   | \$4,800           | Not covered           |  |
|   | You + children   | \$3,900           | Not covered           |  |
|   | You + spouse/partner<br>+ children   | \$5,700           | Not covered           |  |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | 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> .   |

|   |   |   |
|---|---|---|
| <p><b>Will you pay less if you use a <u>network provider</u>?</b></p>   | <p>Generally, yes. Contact your claims administrator for a list of network providers.</p> <ul style="list-style-type: none"> <li>• For Aetna visit, Aetna.com or call 1-877-320-4577</li> <li>• For Anthem BCBS, visit anthem.com or call 1-866-418-7749</li> <li>• For UnitedHealthcare, visit myuhc.com or call 1-800-842-9722</li> </ul> | <p>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.</p> |
| <p><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></p> | <ul style="list-style-type: none"> <li>• No for Aetna</li> <li>• No for Anthem BCBS</li> <li>• Yes for UnitedHealthcare</li> </ul>  | <ul style="list-style-type: none"> <li>• Aetna: You can see the <u>specialist</u> you choose without a <u>referral</u>.</li> <li>• Anthem BCBS: You can see the <u>specialist</u> you choose without a <u>referral</u>.</li> <li>• UnitedHealthcare: This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u>.</li> </ul>   |



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 (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 | <ul style="list-style-type: none"> <li>• \$25 office visit copay</li> <li>• 20% coinsurance all other charges (even if related to office visit)</li> </ul> | Not covered                                     | 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. For UnitedHealthcare Illinois only: You are required to designate a PCP.  |
|  | <u>Specialist</u> visit                          | <ul style="list-style-type: none"> <li>• \$45 office visit copay</li> <li>• 20% coinsurance all other charges (even if related to office visit)</li> </ul> | Not covered                                     | <ul style="list-style-type: none"> <li>• 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.</li> <li>• Infertility/fertility: pre-service authorization required, \$25,000 lifetime max for medical services and \$10,000 lifetime max for related prescriptions</li> <li>• Chiropractic†: 26-visit limit annually</li> <li>• Acupuncture†: 26-visit limit annually</li> <li>• Therapies† (all physical, occupational, and speech combined): 90-visit limit annually</li> </ul> <p>† \$25 office visit copay applies</p> |

\* For more information about limitations and exceptions, see the summary plan description at [teamworks.wellsfargo.com](https://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 (You will pay the least)   | Out-of-network Provider (You will pay the most)  |  |
|  | <u>Preventive care/ screening/immunization</u> | No charge  | Not covered  | 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.  |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)     | 20% coinsurance  | Not covered  | <ul style="list-style-type: none"> <li>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</li> <li>Pre-service authorization required for imaging services</li> </ul>  |
|  | Imaging (CT/ PET scans, MRIs)                  | 20% coinsurance  | Not covered  |  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="http://express-scripts.com">express-scripts.com</a> | Generic drugs                                  | <ul style="list-style-type: none"> <li>\$10 copay per retail prescription</li> <li>\$20 copay per Express Scripts Home Delivery (mail order) prescription</li> </ul>                             | <ul style="list-style-type: none"> <li>\$10 copay per retail prescription</li> <li>Mail order – not covered</li> </ul>             | <ul style="list-style-type: none"> <li>Deductible doesn't apply to copay. Copay doesn't count toward deductible.</li> <li>Retail: covers up to a 30-day supply; CVS/Pharmacy store also covers 31- to 90-day supply for Express Scripts Home Delivery copay</li> <li>Out-of-network retail: you pay copay plus difference between full cost and the Express Scripts discounted amount</li> <li>In-network Express Scripts Home Delivery: 31- to 90-day supply</li> <li>Generic and single-source brand name contraceptives in-network coverage: 100%</li> <li>Pre-service authorization required for some medications</li> </ul> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> </ol> |
|  | Preferred brand drugs                          | <ul style="list-style-type: none"> <li>\$45 copay<sup>1,2</sup> per retail prescription</li> <li>\$90 copay<sup>1,2</sup> per Express Scripts Home Delivery (mail order) prescription</li> </ul> | <ul style="list-style-type: none"> <li>\$45 copay<sup>2</sup> per retail prescription</li> <li>Mail order – not covered</li> </ul> |  |
|  | Non-preferred brand drugs                      | <ul style="list-style-type: none"> <li>\$75 copay<sup>2</sup> per retail prescription</li> <li>\$150 copay<sup>2</sup> per Express Scripts Home Delivery (mail order) prescription</li> </ul>    | <ul style="list-style-type: none"> <li>\$75 copay<sup>2</sup> per retail prescription</li> <li>Mail order – not covered</li> </ul> |  |
|  | <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  |  |

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| Common Medical Event                    | Services You May Need                          | What You Will Pay                            |   | Limitations, Exceptions, & Other Important Information*   |
|---|--|--|---|---|
|   |  | In-network Provider (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                              | Not covered                                     | <ul style="list-style-type: none"> <li>If more than one surgical procedure, all other procedures considered at 50% of allowed amount.</li> <li>If an out-of-network surgeon assists the in-network primary surgeon, asst. surgeon fees considered as percentage of allowed amount for primary surgeon.</li> <li>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.</li> </ul>   |
|   | Physician/surgeon fees                         | 20% coinsurance                              | Not covered                                     |   |
| If you need immediate medical attention | <u>Emergency room care</u>                     | 20% coinsurance                              | 20% coinsurance                                 | In-network deductible and out-of-pocket applies. You are responsible for balance-billing charges from an out-of-network emergency provider.   |
|   | <u>Emergency medical transportation</u>        | 20% coinsurance                              | 20% coinsurance                                 | In-network deductible and out-of-pocket applies. You are responsible for balance-billing charges from an out-of-network emergency provider.   |
|   | <u>Urgent care</u>                             | \$45 copay                                   | Not covered                                     | <ul style="list-style-type: none"> <li>Convenience care in retail setting (such as, Minute Clinic) – in-network \$25 copay; out-of-network not covered</li> <li>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.</li> </ul>   |
| If you have a hospital stay             | Facility fee (e.g., hospital room)             | 20% coinsurance                              | Not covered                                     | <ul style="list-style-type: none"> <li>Pre-service authorization required.</li> <li>If more than one surgical procedure, all other procedures are considered at 50% of allowed amount.</li> <li>If an out-of-network surgeon assists the in-network primary surgeon, asst. surgeon fees considered as percentage of allowed amount for primary surgeon.</li> <li>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.</li> </ul> |
|   | Physician/surgeon fees                         | 20% coinsurance                              | Not covered                                     |   |

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| Common Medical Event   | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information*  |
|--|---|--|---|--|
|  |   | In-network Provider (You will pay the least)   | Out-of-network Provider (You will pay the most) |  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | <ul style="list-style-type: none"> <li>• \$25 office visit copay</li> <li>• 20% coinsurance all other charges (even if related to office visit)</li> </ul>   | Not covered                                     | 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.   |
|  | Inpatient services                        | 20% coinsurance  | Not covered                                     | Pre-service authorization required   |
| <b>If you are pregnant</b>   | Office visits                             | <ul style="list-style-type: none"> <li>• \$25 copay PCP or OB/GYN office visit</li> <li>• \$45 copay specialist office visit</li> <li>• 20% coinsurance all other charges (even if related to office visit)</li> </ul> | Not covered                                     | <p>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.</p> <p>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>.</p>   |
|  | Childbirth/delivery professional services | 20% coinsurance  | Not covered                                     | <ul style="list-style-type: none"> <li>• Pre-service authorization required for hospital stay greater than 48 hours for vaginal delivery, 96 hours for Cesarean delivery</li> <li>• Global bill: claims processing varies, see the "Maternity care" section in Chapter 2: Medical Plans of the <i>Benefits Book</i></li> <li>• 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</li> </ul> |
|  | Childbirth/delivery facility services     | 20% coinsurance  | Not covered                                     |  |

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| Common Medical Event  | Services You May Need            | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information*   |
|---|----------------------------------|--|---|---|
|   |                                  | In-network Provider (You will pay the least)   | Out-of-network Provider (You will pay the most) |   |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | 20% coinsurance  | Not covered                                     | <ul style="list-style-type: none"> <li>• 100-visit limit annually combined with extended skilled nursing care services</li> <li>• Pre-service authorization required</li> </ul>   |
|   | <u>Rehabilitation services</u>   | <ul style="list-style-type: none"> <li>• \$25 copay PCP office visit</li> <li>• \$45 copay specialist office visit</li> <li>• 20% coinsurance all other charges (even if related to office visit)</li> </ul> | Not covered                                     | <ul style="list-style-type: none"> <li>• 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</li> <li>• 90-visit limit annually: combined physical, occupational, and speech therapy, rehabilitation and habilitation services combined</li> <li>• Habilitation services are only covered for children up to their 18th birthday</li> </ul> |
|   | <u>Habilitation services</u>     |  |   |   |
|   | <u>Skilled nursing care</u>      | 20% coinsurance  | Not covered                                     | <ul style="list-style-type: none"> <li>• 100-day limit annually in a skilled nursing facility</li> <li>• Extended skilled nursing care – 100-visit limit annually combined with home health care</li> <li>• Pre-service authorization required</li> </ul>   |
|   | <u>Durable medical equipment</u> | 20% coinsurance  | Not covered                                     | Pre-service authorization required for single item costing \$1,000 or more  |
|   | <u>Hospice services</u>          | 20% coinsurance  | Not covered                                     | Pre-service authorization required  |
| <b>If your child needs dental or eye care</b>                         | 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](https://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](http://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](http://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](http://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.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijiggo 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** \$ 500
- **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:**

| <i>Cost Sharing</i>               |                 |
|-----------------------------------|-----------------|
| <u>Deductibles</u>                | \$ 500          |
| <u>Copayments</u>                 | \$ 10           |
| <u>Coinsurance</u>                | \$ 2,400        |
| <i>What isn't covered</i>         |                 |
| Limits or exclusions              | \$ 60           |
| <b>The total Peg would pay is</b> | <b>\$ 2,970</b> |

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

- **The plan's overall deductible** \$ 500
- **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:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$ 500         |
| <u>Copayments</u>                 | \$ 700         |
| <u>Coinsurance</u>                | \$ 80          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$ 20          |
| <b>The total Joe would pay is</b> | <b>\$1,300</b> |

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

- **The plan's overall deductible** \$ 500
- **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:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$ 500         |
| <u>Copayments</u>                 | \$ 200         |
| <u>Coinsurance</u>                | \$ 300         |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$ 0           |
| <b>The total Mia would pay is</b> | <b>\$1,000</b> |

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