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, call Compass Health Administrators at 1-888-379-3785 or www.manco-compass.com. 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 call 1-888-379-3785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Participating Providers:** $750 Covered Person / $1,500 Family Unit **Non-Participating Providers:** $2,000 Covered Person / $4,000 Family Unit	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes,** preventive care, physician office visits and generic prescription drug co-payments from Participating Providers.	For example, this plan covers certain preventive care services without cost-sharing and before you meet your deductible. See a list of covered preventive care services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	**Yes, for brand-name prescription drugs.** $100 Covered Person / $100 for each member of a Family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Participating Providers:** $4,000 Covered Person / $8,000 Family Unit **Non-Participating Providers:** $10,000 Covered Person / $20,000 Family Unit	If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out of pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, penalty for failure to obtain preauthorization for certain services 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?	**Yes.** See www.blueshieldca.com or call 1-800-219-0030 Option 1 for a list of Participating Providers.	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 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.

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[* For more information about limitations and exceptions, see the plan or policy document at lheidrich@mancoabbott.com.]

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
		Participating Provider (You will pay the least)	Non-Participating 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 copay/visit	50% coinsurance	Deductible does not apply to Participating Provider visits.
	Specialist visit	$25 copay/visit	50% coinsurance	
	Preventive care/screening/ immunization	None	50% coinsurance	You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive. Then check what this plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Services must be preauthorized to avoid a $500 penalty or denial. Call Blue Shield at 1-800-541-6652.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rxipm.com	Generic drugs	Retail: $10 copay/prescription Mail order: $20 copay/prescription	Not covered	None
	Formulary brand drugs	Retail: $30 copay/prescription Mail order: $20 copay/prescription	Not covered	None
	Non-formulary brand drugs	Retail: $50 copay/prescription Mail order: $100 copay/prescription	Not covered	None
	Specialty drugs	20% coinsurance up to maximum $150	Not covered	No coverage for mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at lheidrich@mancoabbott.com.]

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
If you need immediate medical attention	Emergency room care	$250 copay/visit (waived if admitted)		No coverage for services not medically necessary (see DEFINED TERMS section of *Plan Document and Summary Plan Description*)
	Emergency medical transportation	20% coinsurance	50% coinsurance	No coverage for services not medically necessary (see DEFINED TERMS of *Plan Document and Summary Plan Description*)
	Urgent care	Stand-alone clinic: $50 copay/visit Facility: 20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission plus 20% coinsurance	$250 copay/admission plus 50% coinsurance	Services must be preauthorized to avoid a $500 penalty or denial. Call Blue Shield at 1-800-541-6652.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	50% coinsurance	None
	Inpatient services	$250 copay/admission plus 20% coinsurance	$250 copay/admission plus 50% coinsurance	Services must be preauthorized to avoid a $500 penalty or denial. Call Blue Shield at 1-800-541-6652.
If you are pregnant	Office visits	$25 copay/visit	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	$250 copay/admission plus 20% coinsurance	$250 copay/admission plus 50% coinsurance	Services must be preauthorized to avoid a $500 penalty or denial when admission is longer than 48 hours after a vaginal delivery or 96 hours after a cesarean delivery. Call Blue Shield at 1-800-541-6652.

[* For more information about limitations and exceptions, see the plan or policy document at lheidrich@mancoabbott.com.]

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
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 days per calendar year. Services must be preauthorized to avoid a $500 penalty or denial. Call Blue Shield at 1-800-541-6652.
	Rehabilitation services	20% coinsurance	50% coinsurance	None
	Habilitation services	20% coinsurance	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year. Services must immediately follow a hospital stay *and* be preauthorized to avoid a $500 penalty or denial. Call Blue Shield at 1-800-541-6652.
	Durable medical equipment	20% coinsurance	50% coinsurance	Services over $1,000 must be preauthorized to avoid a $500 penalty or denial. Call Blue Shield at 1-800-541-6652.
	Hospice services	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Only routine eye exams performed as part of a child's preventive care medical exam are covered under medical plan.
	Children's glasses	Not covered	Not covered	Refer to MES vision plan.
	Children's dental check-up	Not covered	Not covered	Refer to Ameritas dental plan.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care
- Emergency coverage when traveling outside the U.S. See www.bcbs.com.
- Private duty nursing

[* For more information about limitations and exceptions, see the plan or policy document at lheidrich@mancoabbott.com.]

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Contact information is: Department of Labor's Employee Benefits Security Administration at 1-800-444-EBSA(3272) or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families. 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 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: Compass Health Administrators at 1-888-379-3785 or www.manco-compass.com or Department of Labor's Employee Benefits Security Administration at 1-800-444-EBSA(3272) or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-888-379-3785.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-379-3785.
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-888-379-3785.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-379-3785.

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 plan or policy document at lheidrich@mancoabbott.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 $750**
- **Specialist *[cost sharing]* $25**
- **Hospital (facility) *[cost sharing]* $250+20%**
- **Other *[cost sharing]* 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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$340
Coinsurance	$2,330
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,480**

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

- **The plan's overall deductible $750**
- **Specialist *[cost sharing]* $25**
- **Hospital (facility) *[cost sharing]* $250+20%**
- **Other *[cost sharing]* $100 (brand name drug deductible) + 20% (other services)**

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$850
Copayments	$950
Coinsurance	$270
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,130**

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

- **The plan's overall deductible $750**
- **Specialist *[cost sharing]* $25**
- **Hospital (facility) *[cost sharing]* $250+20%**
- **Other *[cost sharing]* 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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$280
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,220**

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