

 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, go to [www.loomisco.com](http://www.loomisco.com) or call 1-800-346-1223. 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 [www.loomisco.com](http://www.loomisco.com) or call 1-800-346-1223 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$3,000 individual / \$6,000 family; for <a href="#">out-of-network providers</a> \$3,000 individual / \$6,000 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , emergency care and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$6,350 individual / \$12,700 family; for <a href="#">out-of-network providers</a> \$6,350 individual / \$12,700 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.loomisco.com">www.loomisco.com</a> or call 1-800-346-1223 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit <i>Deductible Waived</i>	Not covered	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit <i>Deductible Waived</i>	Not covered	None
	<a href="#">Preventive care/screening</a> /immunization	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a> <i>After Deductible</i>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a> <i>After Deductible</i>	Not covered	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.loomisco.com</a>	Generic drugs (Tier 1)	Retail 50% coinsurance up to \$125 per prescription / mail order is not covered <i>After Deductible</i>	Not covered	Covers up to a 30-day supply (retail subscription).
	Preferred brand drugs (Tier 2)			
	Non-preferred brand drugs (Tier 3)			
	<a href="#">Specialty drugs</a> (Tier 4)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> <i>After Deductible</i>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">copay</a> <i>Deductible Waived</i>	\$500 <a href="#">copay</a>	Co-pay is waived if admitted
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> <i>After Deductible</i>	30% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> /visit <i>Deductible Waived</i>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a> <i>After Deductible</i>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a> <i>After Deductible</i>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (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	\$50 <a href="#">copay</a> /office visit <i>Deductible Waived</i> and 30% <a href="#">coinsurance</a> After <i>Deductible</i> for other outpatient services	Not covered	None
	Inpatient services	30% <a href="#">coinsurance</a> After <i>Deductible</i>	Not covered	
If you are pregnant	Office visits	\$30 <a href="#">copay</a> <i>Deductible Waived</i>	Not covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a> After <i>Deductible</i>	Not covered	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a> After <i>Deductible</i>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a> After <i>Deductible</i>	Not covered	40 visits/year
	<a href="#">Habilitation services</a>	\$50 <a href="#">copay</a> <i>Deductible Waived</i>	Not covered	Refer to SPD for visit limitations.
	<a href="#">Rehabilitation services</a> <a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a> After <i>Deductible</i>	Not covered	<a href="#">Preauthorization</a> is required. 30 visits/calendar year
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a> After <i>Deductible</i>	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a> After <i>Deductible</i>	Not covered	Limited to a combined 210 days.
If you need dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

## 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
- Hearing Aids
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care
- 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
- Long Term Care (*hospital*)

**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: 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 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 Loomis Company at 1-800-346-1223 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](#).

-----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 copayment](#) \$50
- Hospital (facility) [coinsurance](#) 70%
- Other [coinsurance](#) 70%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$2,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,960</b>

**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 copayment](#) \$50
- Hospital (facility) [coinsurance](#) 70%
- Other [coinsurance](#) 70%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$300
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,020</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 70%
- Other [coinsurance](#) 70%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,100</b>