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 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 or call 1-800-346-1223 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $0 individual / $0 family; for out-of-network providers $3,000 individual / $6,000 family	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?	No	This plan does not have a deductible to satisfy.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $9,000 individual / $18,000 family	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, 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, 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.loomisco.com or call 1-800-346-1223 for a list of network 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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% coinsurance	None
	Specialist visit	$50 copay/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	Out of network facility fee is paid at the network benefit level.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.loomisco.com	Generic drugs (Tier 1)	$0 copay retail & $0 mail order	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$40 copay retail & $75 mail order	Not covered	
	Non-preferred brand drugs (Tier 3)	$60 copay retail & $180 mail order	Not covered	
	Specialty drugs (Tier 4)	Paid as any other Drug	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay		Preauthorization is required.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$500 copay	$500 copay	Co-pay is waived if admitted
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	$20 copay/visit		None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	$500 copay per admission, then 30% coinsurance	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	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	$30 copay/office visit and $250 copay for other outpatient services	$250 copay, then 30% coinsurance	None
	Inpatient services	$500 copay per admission	$500 copay per admission, then 30% coinsurance	
If you are pregnant	Office visits	$20 copay	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$250 copay	$250 copay, then 30% coinsurance	
	Childbirth/delivery facility services	$500 copay per admission	$500 copay per admission, then 30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$50 copay	30% coinsurance	40 visits/year
	Habilitation services	$50 copay	30% coinsurance	Refer to SPD for visit limitations.
	Rehabilitation services	$500 copay per admission	$500 copay per admission, then 30% coinsurance	Preauthorization is required. 30 visits/calendar year
	Skilled nursing care			
	Durable medical equipment	0% coinsurance	30% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	0% coinsurance	30% coinsurance	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. 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: 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.

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	$0
Specialist copayment	$50
Hospital (facility) copayment	$500
Other copayment	$250

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	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$560

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$500
Other copayment	$250

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	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$820

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$500
Other copayment	$250

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	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$800

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