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 1-800-367-3721. 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 1-800-367-3721 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 Individual or $3,000 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?	Yes. Preventive care and some services with a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 individual / $12,700 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, pre-notification penalties, 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?	No.	This plan does not use a provider network.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit		All charges are subject to the reference-based reimbursement arrangement.
	Specialist visit	$30 copay/visit		
	Preventive care/screening/ immunization	No charge		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)	20% coinsurance		All charges are subject to the reference-based reimbursement arrangement.
	Imaging (CT/PET scans, MRIs)	20% coinsurance		Preauthorization is required. All charges are subject to the reference-based reimbursement arrangement.
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)	$5 copay retail & $10 copay mail order	Out-of-Network prescription drug benefits are reimbursed at 50% of the pharmacy network rate after satisfaction of the applicable co-payment.	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Retail co-payment increases 3X the amount shown for 90-day prescription fills at the retail level. *Coverage may be available outside this Plan.
	Preferred brand drugs (Tier 2)	$25 copay retail & $50 copay mail order		
	Non-preferred brand drugs (Tier 3)	$50 copay retail & $100 copay mail order		
	Specialty drugs (Tier 4)	Not Covered*		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance		Preauthorization is required. All charges are subject to the reference-based reimbursement arrangement.
	Physician/surgeon fees	20% coinsurance		None
If you need immediate medical attention	Emergency room care	$250 copay		Co-pay is waived if admitted.
	Emergency medical transportation	20% coinsurance		All charges are subject to the reference-based reimbursement arrangement.
	Urgent care	$60 copay/visit		None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance		All charges are subject to the reference-based reimbursement arrangement.
	Physician/surgeon fees	20% coinsurance		

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	None
	Inpatient services	20% coinsurance	Preauthorization is required. All charges are subject to the reference-based reimbursement arrangement.
If you are pregnant	Office visits	$30 copay/visit	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). All charges are subject to the reference-based reimbursement arrangement.
	Childbirth/delivery professional services	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Limited to 100 visits per year. Preauthorization is required. All charges are subject to the reference-based reimbursement arrangement.
	Rehabilitation services	$30 copay/visit	Preauthorization is required. All charges are subject to the reference-based reimbursement arrangement. Limited to 24 visits per calendar year for Chiropractic Care. Unlimited visits per calendar year for Physical, Hearing, Massage, Occupational and Speech.
	Habilitation services	Not Covered	None
	Skilled nursing care	20% coinsurance	Limited to 100 visits per year. Preauthorization is required. All charges are subject to the reference-based reimbursement arrangement.
	Durable medical equipment	20% coinsurance	Preauthorization is required. All charges are subject to the reference-based reimbursement arrangement.
	Hospice services	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	None
	Children's glasses	Not Covered	None
	Children's dental check-up	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.)

- 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 (Adult)
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic Care
- Long Term Care *(Hospital)*
- Weight Loss Programs *(Morbid Obesity)*

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 1-800-367-3721 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 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 [1-800-367-3721.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-800-367-3721.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [1-800-367-3721.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-800-367-3721.]

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	$1,000
Specialist copayment	$30
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:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,370**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
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:

Cost Sharing	
Deductibles	$900
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
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:

Cost Sharing	
Deductibles	$1,000
Copayments	$250
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,320**

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