
 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 1-877-959-9952. 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 1-877-959-9952 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	No Deductible.	See the common medical events chart below for your costs for services the plan covers.
Are there services covered before you meet your deductible ?	No.	You will have to meet the deductible before the plan pays for any services.
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 ?	You will never pay more than the annual maximum as directed by Health and Human Services (HHS) under the guidance of the Code of Federal Regulations and Section 1302(c)(1) of the Affordable Care Act (ACA).	Refer to your Summary Plan Description (SPD) for additional information in the Schedule of Benefits section under out-of-pocket-limitation.
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 1-877-959-9952 for a list of network providers .	This plan uses a provider network . 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	Not Covered		Limited to three (3) visits per plan year.
	Specialist visit	Not Covered	Not Covered		None
	Preventive care/screening/immunization	No charge	Not Covered		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)	Not Covered	Not Covered		None
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered		None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.loomisco.com		Retail 30-day	Retail / Mail-Order 35-60 days	Retail / Mail-order 61-90 days	The Department of Health and Human Services (HHS) has compiled a list of prescription drug benefits that will be covered by this Plan with no patient cost sharing. Additional information can be found under this provision by visiting http://www.healthcare.gov . Note: It is advised to check this list regularly as it is subject to change without notice.
	Generic drugs (Tier 1)	\$1 copay	\$2 copay	\$3 copay	
	Preferred brand drugs (Tier 2)	10% coinsurance			
	Non-preferred brand drugs (Tier 3)	20% coinsurance			
	Specialty drugs (Tier 4)	Not Covered			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered		None
	Physician/surgeon fees	Not Covered	Not Covered		None
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered		None
	Emergency medical transportation	Not Covered	Not Covered		None
	Urgent care	\$50 copay/visit	Not Covered		Limited to three (3) visits per plan year.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered		None
	Physician/surgeon fees	Not Covered	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	Not Covered	Not Covered	None
	Inpatient services	Not Covered	Not Covered	None
If you are pregnant	Office visits	Not Covered	Not Covered	None
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	None
	Rehabilitation services	Not Covered	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	Not Covered	Not Covered	None
	Hospice services	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Covered to the extent required under Section 2713 of the Affordable Care Act (ACA).		None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Covered to the extent required under Section 2713 of the Affordable Care Act (ACA).		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
- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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.)

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 1-877-959-9952 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? No.

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 1-877-959-9952.

—————*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	N/A
■ Hospital (facility) coinsurance	N/A
■ Other coinsurance	N/A

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$12,700
The total Peg would pay is	\$12,700

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	N/A
■ Hospital (facility) coinsurance	N/A
■ Other coinsurance	N/A

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$90
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$4,125
The total Joe would pay is	\$4,515

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	N/A
■ Hospital (facility) coinsurance	N/A
■ Other coinsurance	N/A

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$2,800
The total Mia would pay is	\$2,800