**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 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 1-800-361-3721 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers $500 individual / $1,000 family; for out-of-network providers $1,000 individual / $2,000 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 PPO Preventive care visits, office visits and diagnostic services 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 deductible for specific services. |
| **What is the out-of-pocket limit for this plan?** | For network providers $3,500 individual / $7,000 family; for out-of-network providers $8,000 individual / $16,000 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. *The Prescription Drug section of the Plan contains a separate out-of-pocket limit of $2,850 individual / $5,700 family.* |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, non-network transplant expenses 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 1-800-361-3721 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 | $25 copay/visit | 50% coinsurance | None |
| | Specialist visit | $25 copay/visit | 50% coinsurance | |
| | Preventive care/screening/ immunization | No charge | 50% 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) | 10% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 50% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.loomisco.com | Value Drugs | $2 / $6 copay retail & $6 copay mail-order | Not covered | Covers up to a 30 or up to a 90-day supply (retail subscription); 31-90 day supply (mail order prescription). |
| | Generic drugs | $10 / $30 copay retail & $30 copay mail-order | Not covered | |
| | Preferred brand drugs | $30 / $90 copay retail & $90 copay mail-order | Not Covered | |
| | Non-preferred brand drugs | $50 /$150 copay retail & $150 copay mail-order | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 10% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $200 copay, then 10% coinsurance | Paid at network level | Co-pay is waived if admitted. |
| | Emergency medical transportation | 10% coinsurance | Paid at network level | None |
| | Urgent care | $25 copay/visit | 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 10% coinsurance | 50% 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 | $25 copay/visit | 50% coinsurance | None |
| | Inpatient services | 10% coinsurance | 50% coinsurance | Preauthorization is required. |
| **If you are pregnant** | Office visits | $25 copay/visit | 50% 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 | 10% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 50% coinsurance | 130 visits/year.<br>Preauthorization is required. |
| | Habilitation services | $25 copay/visit | 50% coinsurance | 30 visits each/year. Includes physical, speech and occupational therapy.<br>Preauthorization is required for speech therapy |
| | Rehabilitation services | 10% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 10% coinsurance | 50% coinsurance | Preauthorization is required.<br>Limited to 60 days per year. |
| | Durable medical equipment | 10% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Hospice services | 10% coinsurance | 50% coinsurance | Preauthorization is required. |
| **If you need dental or eye care** | Eye exam | No Charge | No Charge | Includes refractions<br>Limited to one exam per calendar year. |
| | Glasses | No Charge | No Charge | Maximum benefit of $200 every calendar years for all vision hardware expenses combined for ages 0 -17; Maximum benefit of $200 every two calendar years for all vision hardware expenses combined for ages 18 and older. |
| | 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.)**

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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.)**

- Acupuncture
- Chiropractic Care
- Long Term Care *(hospital)*
- Routine Eye Care

**Your Rights to Continue Coverage:** 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.

**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 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 1-800-361-3721.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-361-3721.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-361-3721.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-361-3721.]

*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 | $500 |
| Specialist copayment | $25 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $74 |
| Coinsurance | $1,240 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,874** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copayment | $25 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $826 |
| Coinsurance | $186 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,567** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copayment | $25 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $375 |
| Coinsurance | $142 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,017** |

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