



The Secure Plans

through The Loomis Company

Savings Simplified

Level Premium Self-Funded Medical Coverage
Featuring Reference Based Pricing

Administered by



www.SecurePlans.Info

SPMB20221201

Why Self-Fund?

There's nothing wrong with traditional health care coverage. You pay a monthly fee and outsource your medical plan to an insurance company or HMO. You know what you'll pay each year and your carrier does all the work. Who keeps the savings when claims are less than expected? With traditional coverage, the answer is the insurance carrier, not you.

Fortunately, you have another option: fixed-cost self-funded medical coverage. You pay a monthly fee. You outsource health plan administration. Just like with traditional health care, you know what you'll pay each year and experts administer your plan. Best of all, when claims are less than anticipated, you—not the carrier—keep the savings.

Self-funding delivers other advantages, too. You offer the same plan to employees -- even in different states -- because self-funded plan benefits are governed by state, not federal law. And the monthly cost is frequently comparable to—or less than—traditional insurance.

Great advantages means great responsibility. With self-funded health plans, you (the plan sponsor) are responsible for claims. That's why "pure" self-insurance is better suited for extremely large companies with very big pockets. For the rest of us, it makes more sense to cap employers' claims liability with stop-loss coverage.

Upside opportunity. Downside protection.

That's the beauty of self-funding when it is combined with stop-loss coverage. When claims are higher than expected you're protected; when they're lower you reap the savings.



**Keep the savings
or gift it to
an insurance
company.**

**The choice
really is that
simple.**

Why the Secure Plans?

Self-funding can be complicated, but it doesn't have to be. We've designed the Secure Plans to make things easy and straightforward.

And while self-funding carries some risks, the Secure Plans keep things safe by limiting exposure to high claims, delivering comprehensive benefits, and encouraging preventive care.



Safe

Claims, billing and other operations are provided through The Loomis Company, one of the nation's largest third party administrators.

Stop-loss coverage is provided by highly rated carriers on which you can rely.



Simple

Plan designs like those of fully-insured plans are easy to understand. Reference Based Pricing means no hunting for in-network providers, but optional networks are available.



Fixed-Cost

Your monthly costs are determined up-front. Your responsibility for claims is capped, too. And composite rates mean employers know the medical premium of new hires.



Self-Funded

With the Secure Plans, employers receive 100% of any surplus claim fund dollars. We're not like those self-funded programs that keep 30% or more and require groups to renew to get any refund.



Plus Refund AssistersSM

Self-Funding offers the possibility of refunds when claims are lower than anticipated. The Secure Plans help you seize that potential with Refund AssistersSM: wellness and telemedicine programs that maximize benefit dollars.



We keep things easy.

So everyone can secure the benefits – and savings – of self-funding.



Heads you win,
tails you don't
lose.

What to Know

Brokers are critical to helping employers determine if self-insurance and Reference Based Pricing is the best choice. Here are some items to help your discussion.

Terms

Just like with traditional health insurance there are certain terms you need to know when discussing fixed-cost self-funded medical coverage.

Claims Fund: the portion of monthly payments set aside to cover claims. The rest of monthly payments go towards stop-loss coverage, administration, operations, and to legally required fees and taxes.

Claims Fund Surplus: the unused dollars in the **claim fund** after eligible claims are paid out during the **contract period**.

Composite Rates: the cost of coverage is averaged over the entire group as opposed to varying by age. Each employee pays the same rate, adjusted only for the number of their dependents. Composite rating helps employers better budget their benefit dollars.

Contract Period: the time during which eligible claims must be incurred and paid for in order to be eligible and covered by the benefit plan. Expressed as two numbers. The first defines the **plan year** during which covered claims may be incurred. The second indicates the time by which claims must be submitted.

Fixed-Cost: a self-insured arrangement in which employers pay a set amount each month towards administration, stop-loss coverage -- everything but claim costs -- with no additional charges if claims are higher than anticipated.

Plan Year: the months during which incurred claims are covered by the health plan.

Run-Out: the time following the incurred period in which all claims must be submitted and paid in order to be covered by the stop-loss carrier.

Self-Funded (or Self-Insurance): benefit arrangements in which the employer is responsible for claims payment instead of an insurance company. When claims are lower than anticipated, the employer gets the savings.

Stop-Loss Insurance: protects self-insured employers from excessive claims. There are two types: **specific stop-loss** steps in when any individual's claims exceed a specified amount; **aggregate stop-loss** pays eligible claims once your **claims fund** is exhausted. Excess-loss insurance is another name for this coverage.

Reference Based Pricing (RBP): reimbursement arrangements that do away with networks. Medical providers are reimbursed based on a specific formula, usually a multiple of what Medicare pays for the same treatments and services. Many physicians accept this reimbursement as payment-in-full. Others, however, do not. The Secure Plans partner with specialized firms who educate employees and physicians concerning RBP and to minimize balance billing by the providers before -- and after -- claims are incurred.



Getting Your Refund

Getting refunds sounds good. But how do you get them? Simply.

**It's your refund.
You get it all.**

Monthly Payments

It all begins with the plan year. Each month employers make pay for administration and operating expense, stop-loss coverage, taxes, regulatory fees, and toward claims. The amount stays the same unless the number of insureds changes significantly.

The Claims Fund

Eligible claims—those covered by the benefit plan, incurred during your plan year, and submitted and paid for within the contract period—are reimbursed from your claim fund. If eligible claims exceed what's in the claims fund, it's not a problem. Stop-loss coverage pays them.

Your Refund

At the end of the contract period, if claims paid are less than what employers paid in to the claims fund, employers receive a check for the difference. The Secure Plans are not like other programs that keep some of the refund (or all of it if employers don't renew with them). We pay out 100% the refund.

**But
what
about?**

Claim Timing: Not a Problem

Claims can pile up before you pay enough into the claims fund. Some programs make you pay the shortfall; an unanticipated hit to your bottom line. The Secure Plans protect you from this painful bill. We advance these claims costs, then apply future contributions to the claims fund to balance things out.

Claims Past the Plan Year

When you renew with the Secure Plans we automatically extend the payment period to cover claims incurred in the prior year. If you leave the Secure Plans, you still have a six-month run-out period. Employees will need to have claims paid by the end of this six-month period. Late claims are their responsibility to pay, not yours or the stop-loss carrier.

Underwriting Matters

When it comes to self-funded coverage, assessing the health and likely claims for your group is critical.

Underwriting determines your monthly charges for expected claims. Your refund is based on the difference between actual claims and those expected claims.

That's why groups applying for self-funded coverage are fully underwritten. In the absence of claims

experience, all employees and their dependents will be asked to answer health questions—and it's critical they provide complete and accurate answers. Otherwise rates may be modified and stop-loss coverage for the members making misstatements may be rescinded or lowered. This means the plan sponsor (the employer) are responsible for these claims.

Employers Should Consult Their Brokers

The Secure Plans can deliver tremendous benefits to employers, both large and small. Simple and safe, they feature competitive rates, offer the opportunity—and provide tools—for earning refunds, all while helping employees improve and manage their health. Brokers understand employers needs and the options available to them. As important, brokers can help employers understand the responsibilities and obligations that come with the benefits of level-premium self-funded medical plans and Reference Based Pricing.

The Secure Plans Deliver

Self-funding with stop-loss protection is the right choice for many businesses. The Secure Plans offer Refund AssistersSM so they can make this choice with confidence.



Refund AssistersSM

Getting benefit dollars back when claims are lower than expected is why many employers move to level-premium self-insurance programs. Too often, however, these programs do too little to make those refunds a reality. The Secure Plans are different.



Wellness

The best way to reduce health care costs is to stay healthy. That's why the Secure Plans pay members to get their annual physical exam and provide easy-to-use online wellness coaching. In addition, members with specified chronic conditions are offered nurse-coaching on proven health-improving and cost-cutting regimens.



Telemedicine

Think of them as 21st century house calls: a private conversation between you and your doctor. Teladoc, one of the largest, most trusted telemedicine providers, provides convenient access to board-certified, U.S.-based doctors and pediatricians. Better still, telemedicine doctor visits are subject to a lower co-pay.



100% of the Refund

Getting that refund check when claims are lower than expected is a major reason employers choose to self-fund health care coverage. It is, after all, the employer's money. Yet some level-premium plans don't see it that well. They require groups to renew in order to get *any* refund. Or they take a large cut from the refund. We think that's wrong. Employers get 100% of any refund with the Secure Plans.



Anyone can offer refunds.
Our Refund AssistersSM help deliver them.

An All-Star Team

Getting the most from your benefit dollars means working with the best team. That's why the Secure Plans program brings together best-in-class experts with the focus and skills you can count on for outstanding performance.

Reliable Plan Administration

One of the largest third party administrators in the country, **The Loomis Company** provides manages health plan operations, whether it's implementing Reference Based Pricing or integrating with the optional national networks available through the Secure Plans.

The Loomis Company is responsible for:

- Membership services.
- Employer services.
- Claim payments.
- Utilization review.
- Case management.
- Run-Out management.
- Billing.
- COBRA administration.
- Production and distribution of legally required documents*
- Wellness, including cash rewards for members completing annual preventive exams
- Chronic condition management with specified conditions managing and improving their health

**This is not inclusive of all plan notice requirements to which you may be subject.*



Networks or Not, It's a Choice

With Reference Based Pricing there is no *need* for medical networks. Of course, sometimes employers *want these* networks. That's why the Secure Plans offers options. Want a full-on PPO? Opt for a nationwide Cigna PPO network. In addition, you can add 6 Degrees Health Pro Plus to your plan. These are doctors who have already agreed to accept RBP reimbursement as payment in full.

All Secure Plans include the CVS/Caremark pharmacy network except the Cigna pharmacy network accompanies the Cigna PPO medical network.

Reference Based Pricing (RBP)

RBP arrangements are an increasingly popular alternative to traditional PPO and HMO arrangements. Medical provider reimbursements are based on a specified formula. This increases employee choice and lowers cost. The Secure Plans have teamed with 6 Degrees Health, specialists who educate employees and work with providers to minimize balance billing.



Stop-Loss Coverage

Stop-loss coverage limits employers exposure for eligible claim payments. It's their safety net. So with self-funding, employers need to know their stop-loss carrier will be there when needed. Which is why the Secure Plans use A.M. Best Rated A carriers.



Refund AssistersSM
and an All-Star Team
are how we keep our
commitment to you.

SECURE CO-PAY PLANS -RBP

comprehensive benefits with low-cost office visits.

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual preventive examination will receive a \$100 cash reward.

Chronic Condition Compliance: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain receive nurse coaching to improve outcomes and reduce costs..

Healthier Plans

Plan Name

SECURE 500 CO-PAY RBP	SECURE 1000 CO-PAY RBP	SECURE 2000 CO-PAY RBP	SECURE 3000 CO-PAY RBP	SECURE 4000 CO-PAY RBP
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Maximum Lifetime In-Network Benefits

No Lifetime Maximum
(Unlimited)

Annual Deductible

Single	\$500	\$1,000	\$2,000	\$3,000	\$4,000
Family	\$1,000 (Embedded)	\$2,000 (Embedded)	\$4,000 (Embedded)	\$6,000 (Embedded)	\$8,000 (Embedded)

Annual Out-of-Pocket Maximum

Single (Includes Deductible)	\$1,500	\$3,000	\$4,000	\$5,000	\$6,000
Family (Includes Deductible)	\$3,000	\$6,000	\$8,000	\$10,000	\$12,000

Office Visits

In office	Primary Care \$25 Co-pay Specialty \$50 Co-pay				
Telemedicine through Teladoc	\$10 Co-pay				

Professional Services

- Lab & X-Ray
- Maternity

10%	20%
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Hospital & Facility Services

Paid up to a percent of Medicare

Hospital Inpatient	10%	20%
Emergency Room Facility	10%	20%
Emergency Room Physician Services	10%	20%
Urgent Care Center (Physician Services)	\$150 Co-pay (Deductible waived) then covered 100%	

Prescription Drugs

- 30-Day Retail Supply
- Mail Order available
- In-Network Only

Tier 1–Generic Drugs: \$10
 Tier 2–Preferred Brand-Name Drugs: \$35
 Tier 3–Non-Preferred Drugs (Non-Formulary): 50%
 Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to \$300 Co-pay per prescription

Preventive Care

(In-Network Only)

- Well Baby & Well Child: 100% coverage
- Adult Preventive/Wellness Exam: 100% Coverage

0%
Not Subject to Deductible

\$5,000 Deductible option also available.

Please Consult Summary of Benefits & Coverage for benefit details.

IMPORTANT NOTE: RBP plans have no network except for pharmacy benefits. Providers are reimbursed a percentage in excess of Medicare rates. Physicians who have already agreed to accept our RBP reimbursement as payment in full is available through the 6 Degrees Health Pro Plus.

SECURE HSA PLANS - RBP

HSA-compatible plans with a wellness twist.

Health Rewards

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual preventive examination will receive a \$100 cash reward.

Chronic Condition Compliance: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain receive nurse-coaching to improve outcomes and reduce costs.

Plan Name

**SECURE HSA
3000 RBP**

**SECURE HSA
4000 RBP**

**SECURE HSA
5000 RBP**

Maximum Lifetime In-Network Benefits

Annual Deductible

In-Network / Out-of-Network

Single

\$3,000

\$4,000

\$5,000

Family

\$6,000
(Embedded)

\$8,000
(Embedded)

\$10,000
(Embedded)

Annual Out-of-Pocket Maximum

Single (Includes Deductible)

\$5,000

\$5,500

\$6,000

Family (Includes Deductible)

\$10,000

\$11,000

\$12,000

Office Visits

In office

20%

20%

20%

Telemedicine through Teladoc

\$10 Co-pay*

\$10 Co-pay*

\$10 Co-pay*

Professional Services

- Lab & X-Ray
- Maternity

20%

20%

20%

Hospital & Facility Services

Paid up to a percent of Medicare

Hospital Inpatient

20%

20%

20%

Emergency Room Facility

\$250 Co-pay* (waived if admitted)

\$250 Co-pay* (waived if admitted)

\$250 Co-pay* (waived if admitted)

Emergency Room Physician Services

20%

20%

20%

Urgent Care Center (Physician Services)

\$150 Co-pay* then covered 100%

\$150 Co-pay* then covered 100%

\$150 Co-pay* then covered 100%

Prescription Drugs

- 30-Day Retail Supply
- Mail Order available
- In-Network Only

Co-pays apply only after satisfying the Annual Deductible:

Tier 1–Generic Drugs: \$10

Tier 2–Preferred Brand-Name Drugs: \$35

Tier 3–Non-Preferred Drugs (Non-Formulary): 50%

Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to \$300 Co-pay per prescription

Preventive Care

(In-Network Only)

- Well Baby & Well Child: 100% coverage
- Adult Preventive/Wellness Exam: 100% Coverage

0%

Not Subject to Deductible

* Co-pays apply after meeting the annual deductible Please Consult Summary of Benefits & Coverage for benefit details.

IMPORTANT NOTE: RBP plans have no network except for pharmacy benefits. Providers are reimbursed a percentage in excess of Medicare. Physicians who have already agreed to accept our RBP reimbursement as payment in full is available through the 6 Degrees Health Pro Plus.

SECURE CO-PAY PLANS - FULL PPO NETWORK

Comprehensive benefits with low-cost office visits.

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual preventive examination will receive a \$100 cash reward.

Chronic Condition Compliance: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain receive nurse coaching to improve outcomes and reduce costs..

Healthier Plans

Plan Name

**SECURE 500
CO-PAY**

**SECURE 1000
CO-PAY**

**SECURE 2000
CO-PAY**

**SECURE 3000
CO-PAY**

**SECURE 4000
CO-PAY**

Maximum Lifetime In-Network Benefits

No Lifetime Maximum
(Unlimited)

Annual Deductible

In-Network / Out-of-Network

Single

\$500 / \$2,500

\$1,000 / \$3,000

\$2,000 / \$4,000

\$3,000 / \$6,000

\$4,000 / \$6,000

Family

\$1,000 / \$5,000
(Embedded)

\$2,000 / \$6,000
(Embedded)

\$4,000 / \$8,000
(Embedded)

\$6,000 / \$8,000
(Embedded)

\$8,000 / \$12,000
(Embedded)

Annual Out-of-Pocket Maximum

In-Network / Out-of-Network

Single (Includes Deductible)

\$1,500 / \$4,500

\$3,000 / \$5,000

\$4,000 / \$6,000

\$5,000 / \$7,000

\$6,000 / \$8,000

Family (Includes Deductible)

\$3,000 / \$9,000

\$6,000 / \$10,000

\$8,000 / \$12,000

\$10,000 / \$14,000

\$12,000 / \$16,000

Office Visits

In-Network / Out-of-Network

In office

Primary Care
\$25 Co-pay / 30%
Specialty
\$50 Co-pay / 30%

Primary Care
\$25 Co-pay / 40%
Specialty
\$50 Co-pay / 40%

Primary Care
\$25 Co-pay / 40%
Specialty
\$50 Co-pay / 40%

Primary Care
\$25 Co-pay / 40%
Specialty
\$50 Co-pay / 40%

Primary Care
\$25 Co-pay / 40%
Specialty
\$50 Co-pay / 40%

Telemedicine through Teladoc

\$10 Co-pay

\$10 Co-pay

\$10 Co-pay

\$10 Co-pay

\$10 Co-pay

Professional Services

In-Network / Out-of-Network

- Lab & X-Ray
- Maternity

10% / 30%

20% / 40%

Hospital & Facility Services

In-Network / Out-of-Network

Hospital Inpatient

10% / 30%

20% / 40%

Emergency Room Facility

10% / 30%

20% / 40%

Emergency Room Physician Services

10% / 30%

20% / 40%

Urgent Care Center (Physician Services)

\$150 Co-pay (Deductible waived) then covered 100% / 40%

Prescription Drugs

- 30-Day Retail Supply
- Mail Order available
- In-Network Only

Prescription Drug Benefit:
Covered Prescription Drug costs apply towards the
Network Out-of-Pocket Maximum

Tier 1–Generic Drugs: \$10
Tier 2–Preferred Brand-Name Drugs: \$35
Tier 3–Non-Preferred Drugs (Non-Formulary): 50%
Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to \$300 Co-pay per prescription

Preventive Care

(In-Network Only)

- Well Baby & Well Child: 100% coverage
- Adult Preventive/Wellness Exam:
100% Coverage

0%
Not Subject to Deductible

\$5,000 Deductible option also available.

Please Consult Summary of Benefits & Coverage for benefit details.

SECURE HSA PLANS - FULL PPO NETWORK

HSA-compatible plans with a wellness twist.

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual preventive examination will receive a \$100 cash reward.

Chronic Condition Compliance: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain receive nurse-coaching to improve outcomes and reduce costs.

Health Rewards

Plan Name

**SECURE HSA
3000**

**SECURE HSA
4000**

**SECURE HSA
5000**

Maximum Lifetime In-Network Benefits

No Lifetime Maximum
(Unlimited)

Annual Deductible

In-Network / Out-of-Network

Single

\$3,000 / \$5,000

\$4,000 / \$6,000

\$5,000 / \$7,000

Family

\$6,000 / \$10,000
(Embedded)

\$8,000 / \$12,000
(Embedded)

\$10,000 / \$14,000
(Embedded)

Annual Out-of-Pocket Maximum

In-Network / Out-of-Network

Single (Includes Deductible)

\$5,000 / \$7,000

\$5,500 / \$8,000

\$6,000 / \$9,000

Family (Includes Deductible)

\$10,000 / \$14,000

\$11,000 / \$16,000

\$12,000 / \$18,000

Office Visits

In-Network / Out-of-Network

In office

20% / 30%

20% / 30%

20% / 30%

Telemedicine through Teladoc

\$10 Co-pay*

\$10 Co-pay*

\$10 Co-pay*

Professional Services

In-Network / Out-of-Network

- Lab & X-Ray
- Maternity

20% / 30%

20% / 30%

20% / 30%

Hospital & Facility Services

In-Network / Out-of-Network

Hospital Inpatient

20% / 30%

20% / 30%

20% / 30%

Emergency Room Facility

\$250 Co-pay* (waived if admitted)

\$250 Co-pay* (waived if admitted)

\$250 Co-pay* (waived if admitted)

Emergency Room Physician Services

20% / 30%

20% / 30%

20% / 30%

Urgent Care Center (Physician Services)

\$150 Co-pay* then covered 100% / 30%

\$150 Co-pay* then covered 100% / 30%

\$150 Co-pay* then covered 100% / 30%

Prescription Drugs

- 30-Day Retail Supply
- Mail Order available
- In-Network Only

Prescription Drug Benefit:
Covered Prescription Drug costs apply towards the Network Out-of-Pocket Maximum

Co-pays apply only after satisfying the Annual Deductible:

Tier 1–Generic Drugs: \$10

Tier 2–Preferred Brand-Name Drugs: \$35

Tier 3–Non-Preferred Drugs (Non-Formulary): 50%

Tier 4–Specialty Pharmacy and Injectables: 35% Co-insurance up to \$300 Co-pay per prescription

Preventive Care

(In-Network Only)

- Well Baby & Well Child: 100% coverage
- Adult Preventive/Wellness Exam: 100% Coverage

0%
Not Subject to Deductible

* Co-pays apply after meeting the annual deductible

Please Consult Summary of Benefits & Coverage for benefit details.

Exclusions & Limitations

Following is an abbreviated list of exclusions and limitations. Please refer to the Summary Plan Description ("SPD") for comprehensive details. Defined terms are "Capitalized" and can be found in the SPD. Please note that in listing services or examples, we do not intend to limit a list of services or examples unless we state specifically that the list "is limited to".

- Any amounts in excess of maximum amounts stated in the SPD.
- Charges in excess of Eligible Expenses as detailed in the SPD.
- Services or supplies that are not medically necessary.
- Services received before your effective date.
- Services received after your coverage ends.
- Any conditions for which benefits can be recovered under any workers' compensation law or similar law.
- Services provided by a local, state or federal government agency, unless you have to pay for them.
- Services you receive for which you are not legally obligated to pay.
- Services for which no charge is made to you in the absence of insurance coverage.
- Services not listed as covered in the SPD.
- Alternative Treatments such as acupuncture, aromatherapy, hypnosis, Rolfing and art therapy.
- Cosmetic Procedures.
- Custodial care.
- Dental and orthodontic services except as specifically stated in the SPD.
- Devices, appliances and prosthetics except as specifically stated in the SPD. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo esophageal voice prosthetics.
- Replacement of prosthetics and Durable Medical Equipment ("DME") due to misuse, malicious damage, gross neglect or when lost or stolen.
- Domiciliary care.
- Expenses for injury or illness arising out of attempted suicide or an intentional self-inflicted injury, except if the result of a physical or mental medical condition or act of domestic violence and would normally be covered.
- Experimental or Investigational Services, except for services for persons who have been accepted into an approved clinical trial for cancer, or a life threatening Sickness or condition.
- Eye surgery performed solely for the purpose of correcting refractive errors (such as intact corneal implants). Also, Surgery that is intended to allow you to see better without glasses or other vision correction such as LASIK.
- Eyewear including the purchase cost and fitting charge for eyeglasses and contact lenses unless specifically stated in the SPD.
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Foot care that is routine. Examples include the cutting and removal of corns or calluses; hygienic and preventive maintenance foot care; treatment of flat feet; shoe orthotics; shoe inserts; and arch supports. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which benefits are provided under the diabetes services in the SPD. This exclusion does not apply to preventive foot care for those who are at risk of neurological or vascular disease arising from diseases such as diabetes.
- Foreign language and sign language interpreters, except as required by law.
- Genetic testing, except as specifically stated in the SPD.
- Growth hormone therapy.
- Health club memberships.
- Infertility services (including sterilization reversal).
- Medical supplies, except as specifically listed in the SPD.
- Non-injectable medications given in an outpatient or office setting.
- Nutritional counseling except as specified listed as covered in the SPD.
- Obesity reduction services through surgical and non-surgical treatment, except as specifically stated in the SPD.
- Over-the-counter medications and treatments.
- Pain management services using multi-disciplinary pain management programs provided on an inpatient basis.
- Personal care attendant's services.
- Personal comfort items.
- Pharmaceutical products and prescription medication products beyond the specified supply limits and/or specifically excluded in the SPD.
- Pharmaceutical Products or prescription medication products for outpatient use that are filled by a prescription order or refill except as specifically stated in the SPD.
- Pregnancy through a surrogate and any services or supplies provided in connection with a surrogate Pregnancy.
- Private duty nursing.
- Psychosurgery.
- Respite care.
- Sex transformation operations.
- Smoking cessation programs that are stand-alone multi-disciplinary smoking cessation programs, except as covered in the SPD.
- Snoring treatments, both medical and surgical treatment, except as when provided as part of treatment for documented obstructive sleep apnea. Also limited is upper and lower jawbone surgery including that for obstructive sleep apnea.
- Travel or transportation expenses, even if prescribed by a Physician.
- Weight loss programs.
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. This exclusion does not apply to mammography.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.
- Health services for organ and tissue transplants, except those described under Transplantation Services in the SPD.
- Out-of-Network health services provided in a foreign country, unless as required as Emergency Health Services.
- Out-of-Network Preventive Care except as required by law.
- Medicare eligibility results in Benefit payment pursuant to Medicare rules.
- Claims submitted for health services beyond 12 months from the date of service, except as required by law.
- Services performed by a Provider who is a family member by birth or marriage or resides at same residence.
- Dental and orthodontic services except as specifically stated in the SPD.

The Secure Plans offers Reference Based Pricing and PPO network options. The RBP option reimburses medical providers based on a specific formula. The Secure Plan partners with specialists in RBP programs to minimize and avoid balance billing and provide patient advocacy when needed.

The PPO network available through the Secure Plans negotiates discounted rates with in-network providers. Out-of-Network providers may charge a much higher rate. The Secure Plan reimburses these charges based on a formula (usually Medicare reimbursement rates plus 10%). This reduced reimbursement rate will be applied to the out-of-network portion of your out-of-pocket costs (which is separate from the in-network out-of-pocket costs). Insured are responsible for any charges above the Secure Plans out-of-network reimbursement rates. Consequently, if a network is available, insureds are strongly encouraged to use in-network providers.

This brochure provides abridged information about benefits, exclusions, and limitations. For costs and complete information on coverage, you must refer to the SPD about how the Secure Plans work, accessing benefits, benefit limits, service area benefit limitations, pre-service benefit confirmation, compliance rules, and eligible expenses. *that plans consult with their own experts or legal counsel to review all applicable federal and state legal requirements that may apply to their group health plan. By providing this publication and any attachments, The Loomis Company is not exercising discretionary authority over the plan and is not assuming a plan fiduciary role, nor is Company, the program managers (Insurgency Benefits) or your broker providing legal advice.*

The Secure Plans
Administered by



www.SecurePlans.Info