This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.local4funds.org or by calling us at 1-888-486-3524. You may request a copy of the Uniform Glossary by calling us at: 1-888-486-3524 or you can access it online at: www.local4funds.org, www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$200** Individual/**$400** Family. Out-of-Network **$300** Individual/**$600** Family. Combined deductible maximum **$300** Individual/**$600** Family, per calendar year. Doesn't apply to In-network preventive care and most office visits. Coinsurance and Copayments do not count toward deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$250** Individual/**$500** Family for Prescription Drugs. There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** Individual/Family, per calendar year	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, prescription **deductible**, prescription copayments, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, call **1-800-810-2583** or see www.bcbsma.com.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-486-3524 or visit us at www.local4funds.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at: www.local4funds.org, www.dol.gov/ebsa/healthreform and www.cciio.cms.gov, or call us at 1-888-486-3524 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $10) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 10% would be $100. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copayment/office visit	30% coinsurance, after $300 deductible	Exception: No charge for office visit at CVS Minute Clinic. To locate a CVS Minute Clinic in your area visit: www.minuteclinic.com
	Specialist visit	$10 copayment/office visit	30% coinsurance, after $300 deductible	---None---
	Other practitioner office visit	$10 copayment/office visit for Chiropractor, Licensed Acupuncturist, Licensed Massage Therapist and Licensed Homeopathic provider.	30% coinsurance, after $300 deductible for Chiropractor. $10 copayment/office visit for Licensed Acupuncturist, Licensed Massage Therapist and Licensed Homeopathic provider.	Chiropractic limit: 20 visits per person/per calendar year. Acupuncture limit: 20 visits per person/per calendar year. Massage therapy/Homeopathic visits limit: $1,000 combined maximum, per person/per calendar year.
	Preventive care/screening/ immunization	No charge for office visit and related routine lab tests, x-rays, and immunizations. No charge for routine Mammogram. No charge for Flu shots.	30% coinsurance, after $300 deductible	Limited to age-based schedule and/or frequency

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	$10 copayment in office, independent laboratory, or independent radiology facility. 10% coinsurance in facility or hospital outpatient department. 10% coinsurance, after $200 deductible in the emergency room or while inpatient.	30% coinsurance, after $300 deductible	---None---
	Imaging (CT/PET scans, MRIs)	10% coinsurance, after $200 deductible in hospital or hospital outpatient department. No charge for freestanding or other facilities or sites.	30% coinsurance, after $300 deductible	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at: www.local4funds.org	Generic drugs	$20 copayment, retail pharmacy $40 copayment, mail order	Balance-billed charges	Retail pharmacy covers a 1-30 day supply. Mail order covers up to a 90-day supply. Mail order may be obtained at either a retail CVS Pharmacy under our Maintenance Choice Program, or by delivery to your home under the standard mail order service.
	Preferred brand drugs	$40 copayment, retail pharmacy $80 copayment, mail order		
	Non-preferred brand drugs	$80 copayment, retail pharmacy $160 copayment, mail order		
	Specialty drugs	**Generic:** $20 copayment, retail pharmacy $40 copayment, mail order **Preferred:** $40 copayment, retail pharmacy $80 copayment, mail order **Non-preferred brand:** $80 copayment, retail pharmacy $160 copayment, mail order		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance, after $200 deductible	30% coinsurance, after $300 deductible	---None---
	Physician/surgeon fees	10% coinsurance, after $200 deductible		

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	10% coinsurance, after $200 deductible	10% coinsurance, after $300 deductible	---None---
	Emergency medical transportation	10% coinsurance, after $200 deductible	10% coinsurance, after $300 deductible	
	Urgent care	$10 copayment/office visit	30% coinsurance, after $300 deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance, after $200 deductible	30% coinsurance, after $300 deductible	Requires BCBS approval; otherwise the service may not be covered.
	Physician/surgeon fee	10% coinsurance, after $200 deductible		
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copayment/office visit	30% coinsurance, after $300 deductible	Partial Day Hospitalization and/or Intensive Outpatient Treatment Programs require BCBS approval; otherwise the service may not be covered.
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance, after $300 deductible	Requires BCBS approval; otherwise the service may not be covered.
	Substance use disorder outpatient services	$10 copayment/office visit	30% coinsurance, after $300 deductible	Partial Day Hospitalization and/or Intensive Outpatient Treatment Programs require BCBS approval; otherwise the service may not be covered.
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance, after $300 deductible	Requires BCBS approval; otherwise the service may not be covered.
If you are pregnant	Prenatal and postnatal care	10% coinsurance, after $200 deductible, global maternity fee. X-ray/blood work see: **If you have a test** (page 3)	30% coinsurance, after $300 deductible	---None---
	Delivery and all inpatient services	10% coinsurance, after $200 deductible		

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you need help recovering or have other special health needs	Home health care	10% coinsurance, after $200 deductible	30% coinsurance, after $300 deductible	Requires BCBS approval; otherwise the service may not be covered.
	Rehabilitation services	$10 copayment/office visit	30% coinsurance, after $300 deductible	In-network cardiac rehabilitation subject to 10% coinsurance, after deductible.
	Habilitation services	$10 copayment/office visit	30% coinsurance, after $300 deductible	---None---
	Skilled nursing care	10% coinsurance, after $200 deductible	30% coinsurance, after $300 deductible	Limited to 100 days per calendar year. Requires BCBS approval; otherwise the service may not be covered.
	Durable medical equipment	10% coinsurance, after $200 deductible	30% coinsurance, after $300 deductible	---None---
	Hospice service	10% coinsurance, after $200 deductible	30% coinsurance, after $300 deductible	Requires BCBS approval; otherwise the service may not be covered.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Massage Therapy/Homeopathic coverage above the $1,000 combined annual maximum
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Skilled nursing care above the 100 days per calendar year benefit maximum

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at **1-888-486-3524**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us at: **1-888-486-3524**, or U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**. Additionally, a consumer assistance program can help you file your appeal. You can contact Health Care for All, 30 Winter Street Suite 1004, Boston MA, at: **1-800-272-4232** or **www.massconsumerassistance.org**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides. Please note that this Plan is a "grandfathered health plan" under the Affordable Care Act. For more information, please refer to page v of your Summary Plan Description.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,400
- **Patient pays** $1,140

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$200
Copays	$40
Coinsurance	$700
Limits or exclusions	$200
Total	**$1,140**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,870
- **Patient pays** $1,530

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$450
Copays	$900
Coinsurance	$100
Limits or exclusions	$80
Total	**$1,530**

These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program please contact the CVS Caremark Diabetic team at: 1-800-588-4456

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.