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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-486-3524. 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.local4funds.org or www.healthcare.gov/sbc-glossary or call 1-800-486-3524 for a copy. This plan is a "grandfathered health plan" under the Affordable Care Act. To learn more, refer to page v of the Summary Plan Description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $200 Individual/$400 Family per calendar year. Out-of-Network: $300 Individual/$600 Family per calendar year.	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 overall family deductible is met.
Are there services covered before you meet your deductible?	Yes. The calendar-year deductible does not apply to services that are subject to a copay or covered at no cost to you.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay may still apply. For example, a physician office visit will be covered at a $10 copay even if you haven't met the deductible amount. Further, this plan covers certain preventive services, such as a routine physical, without cost sharing before you meet your deductible.
Are there other deductibles for specific services?	Yes. $250 Individual/$500 Family for Prescription Drugs.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
What is the out-of-pocket limit for this plan?	$5,000 Individual/Family, per calendar year.	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If your spouse or other dependents are in the plan, your obligation to pay ends when the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, prescription copays, prescription deductible, balance-billing charges, and health care that 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. For a list of network providers, call 1-800-810-2583 or see www.bluecrossma.com.	The 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 its charge and what the plan pays (balance-billing). Be aware, your network provider may 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 of your choice 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	$10 copay/office visit	30% coinsurance, after $300 deductible	Exception: No charge for office visit at urgent care clinic or CVS Minute Clinic, and no charge for telehealth visit via American Well.
	Specialist visit	$10 copay/office visit	30% coinsurance, after $300 deductible	None
	Preventive care/screening/ immunization	No charge for covered services.	30% coinsurance, after $300 deductible	Covered services include physicals and related routine lab tests, x-rays, and immunizations; routine mammograms or colonoscopies; and flu shots. Limited to age-based schedule and/or frequency. Note: you may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what the plan will pay for.
	Other practitioner office visit	$10 copay/office visit for Chiropractor, Licensed Acupuncturist, Licensed Massage Therapist, and/or Licensed Homeopathic provider.	30% coinsurance, after $300 deductible, for Chiropractor. $10 copay/office visit for Licensed Acupuncturist, Licensed Massage Therapist, and/or Licensed Homeopathic provider.	Chiropractic limit: 20 visits per person per calendar year. Acupuncture limit: 20 visits per person per calendar year. Massage therapy/Homeopathic limit: $1,000 combined maximum per person per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay in office, independent lab, or x-ray facility 10% coinsurance, no deductible applies, in hospital outpatient 10% coinsurance, after $200 deductible, in ER or while inpatient	30% coinsurance after $300 deductible (unless in ER, which is 10% coinsurance after $300 deductible)	None

[* For more information about limitations and exceptions, see the plan or policy document at www.local4funds.org.]

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)	
	Imaging (CT/PET scans, MRIs)	10% coinsurance after $200 deductible in hospital or hospital outpatient	30% coinsurance after $300 deductible (unless in ER, which is 10% coinsurance after deductible)	No charge for in-network freestanding sites or at Shields Health Care Group facilities.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.local4funds.org	Generic drugs (Tier 1)	$20 copay, retail $40 copay, mail order	Balance-billing charges	Retail is 30-day supply; mail order (available at CVS pharmacy or delivery) is 90-day supply.
	Preferred brand drugs (Tier 2)	$40 copay, retail $80 copay, mail order	Balance-billing charges	Retail is 30-day supply; mail order (available at CVS pharmacy or delivery) is 90-day supply.
	Non-preferred brand drugs (Tier 3)	$80 copay, retail $160 copay, mail order	Balance-billing charges	Retail is 30-day supply; mail order (available at CVS pharmacy or delivery) is 90-day supply.
	Specialty drugs	Generic: $20 copay, retail $40 copay, mail order Preferred brand: $40 copay, retail $80 copay, mail order Non-preferred brand: $80 copay, retail $160 copay, mail order	Balance-billing charges	Same as above.
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	30% coinsurance after $300 deductible	None
If you need immediate medical attention	Emergency room care	10% coinsurance after $200 deductible	10% coinsurance after $300 deductible	None
	Emergency medical transportation	10% coinsurance after $200 deductible	10% coinsurance after $300 deductible	None
	Urgent care	No charge	30% coinsurance after $300 deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after $200 deductible	30% coinsurance after $300 deductible	Requires preapproval from Blue Cross Blue Shield (BCBS). Penalty: $250 or denial of admission if not medically necessary.
	Physician/surgeon fees	10% coinsurance after $200 deductible	30% coinsurance after $300 deductible	Requires preapproval from BCBS. Penalty: $250 or denial of admission if not medically necessary.

[* For more information about limitations and exceptions, see the plan or policy document at www.local4funds.org.]

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 Behavioral Health services	$10 copay/office visit	30% coinsurance after $300 deductible	Partial-Day Hospitalization and/or Intensive Outpatient Treatment require preapproval from Modern Assistance Programs (MAP). Penalty: $250 or denial of admission if not medically necessary.
	Inpatient Behavioral Health services	10% coinsurance	30% coinsurance after $300 deductible	Requires preapproval from MAP. Penalty: $250 or denial of admission if not medically necessary.
	Outpatient Substance Abuse services	$10 copay/office visit	30% coinsurance after $300 deductible	Partial-Day Hospitalization and/or Intensive Outpatient Treatment require preapproval from (MAP). Penalty: $250 or denial of admission if not medically necessary.
	Inpatient Substance Abuse services	10% coinsurance	30% coinsurance after $300 deductible	Requires preapproval from MAP. Penalty: $250 or denial of admission if not medically necessary.
If you are pregnant	Office visits	$10 copay/office visit	30% coinsurance after $300 deductible	Global maternity fee for most pre-natal care. Maternity care may include tests and services described elsewhere in SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance after $200 deductible	30% coinsurance after $300 deductible	Same as above.
	Childbirth/delivery facility services	10% coinsurance after $200 deductible	30% coinsurance after $300 deductible	Same as above.
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 preapproval from BCBS. Penalty: $250 or denial of admission if not medically necessary.
	Rehabilitation services	$10 copay/office visit	30% coinsurance after $300 deductible	Covers physical, occupational, and speech therapy. In-network cardiac rehab subject to 10% coinsurance after $200 deductible.
	Habilitation services	$10 copay/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; must be preapproved by BCBS. Penalty: $250 or denial of admission if not medically necessary.
	Durable medical equipment	10% coinsurance after $200 deductible	30% coinsurance after $300 deductible	None

[* For more information about limitations and exceptions, see the plan or policy document at www.local4funds.org.]

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)	
	Hospice services	10% coinsurance after $200 deductible	30% coinsurance after $300 deductible	Requires preapproval from BCBS. Penalty: $250 or denial of admission if not medically necessary.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

[* For more information about limitations and exceptions, see the plan or policy document at www.local4funds.org.]

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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Children)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Massage therapy/Homeopathic coverage above $1,000 combined annual maximum
- 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 above the 100 days per calendar year benefit maximum

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Weight Loss Programs

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 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

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 the 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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，☒☒打☒个号☒ [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

[* For more information about limitations and exceptions, see the plan or policy document at www.local4funds.org.]

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	$450
Specialist copayment	$10
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	$200
Copayments	$270
Coinsurance	$1,150
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,680

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

The plan's overall deductible	$450
Specialist copayment	$10
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	$450
Copayments	$1400
Coinsurance	$170
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,080

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

The plan's overall deductible	$450
Specialist copayment	$10
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	$200
Copayments	$70
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$410

These numbers assume the patient does not participate in the plan's diabetes wellness program, in which case costs may be higher.
For more information about the diabetes wellness program, please contact the CVS Caremark Diabetic Team at 1-800-588-4456.
The plan would be responsible for the other costs of these EXAMPLE covered services.