



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, please visit [www.noituitf.org](http://www.noituitf.org) or call the **NOITU Member Services Dept. at 1-718-291-3434 option 3**. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-718-291-3434 option 3 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$0</b>	Generally, you must pay all of the costs from <a href="#">provider</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductibles</a> ?	Yes, <a href="#">preventive care</a> is covered before you meet your <a href="#">deductible</a>	This <a href="#">plan</a> covers some items and services if you haven't met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">Preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes, <b>\$300</b> per person/ <b>\$600</b> per family for out-of-network services	You must pay all of the cost for these services (out-of-network) up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this plan?	Yes, <b>\$1,500</b> per person/ <b>\$3,000</b> per family for in-network <b>\$1,600</b> per person/ <b>\$3,200</b> per family for prescription drugs None for out-of-network	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year covered services. If you have other family members in this plan, they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">Premiums</a> , balance-billed charges, and health care charges this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of preferred providers see: <a href="http://Empireblue.com">Empireblue.com</a> or call 1-800-810-2583	If you use an in-network doctor or other health care provider, this <a href="#">plan</a> will pay some or all of the costs of the covered services. Be aware, your in-network doctor or hospital may use an <a href="#">out-of-network provider</a> for some services. Plans use the term in-network, preferred or participating providers in their network. See the chart starting on page 2 for how this <a href="#">plan</a> pays different kinds of providers.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</a> .
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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	Your cost if you use an		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	---none---
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	---none---
	<a href="#">Preventive care/screening</a> /immunization	No charge	20% <a href="#">coinsurance</a>	---none---
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	---none---
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	Pre-certification required (See Summary Plan Description for details)
If you need drugs to treat your illness or condition  For more information about your <a href="#">prescription drug coverage</a> call CVS Caremark at 1-888-202-1654	Generic drugs	\$7.50 <a href="#">copay</a>	\$7.50 <a href="#">copay</a>	See Summary Plan Description for details
	Preferred brand drugs	\$30 <a href="#">copay</a>	\$30 <a href="#">copay</a>	See Summary Plan Description for details
	Non-preferred brand drugs	\$50 <a href="#">copay</a>	\$50 <a href="#">copay</a>	See Summary Plan Description for details
	<a href="#">Specialty drugs</a>	\$7.50/\$30/\$50 <a href="#">copay</a> for generic/preferred brand/ non-preferred brand	\$7.50/\$30/\$50 <a href="#">copay</a> for generic/preferred brand/ non-preferred brand	See Summary Plan Description for details
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	See limits in SPD	Pre-certification required
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	---none---

Common Medical Event	Services You May Need	Your cost if you use an		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room services</a>	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> /visit See limits in SPD	---none---
	<a href="#">Emergency medical transportation</a> (Ground)	Balance after Fund pays \$800	20% <a href="#">coinsurance</a> or balance after Fund pays \$800	See Summary Plan Description for details re: air or sea
	<a href="#">Urgent care</a> (Facility)	\$50 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Pre-certification required
	Physician/surgeon fee	No charge	20% <a href="#">coinsurance</a>	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% <a href="#">coinsurance</a>	---none---
	Inpatient services	No charge	See limits in SPD	Pre-certification required
If you are pregnant	Office visits	No charge	20% <a href="#">coinsurance</a>	---none---
	Childbirth/delivery professional services	No charge	20% <a href="#">coinsurance</a>	---none---
	Childbirth/delivery facility services	No charge	See limits in SPD	Pre-certification required
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a>	Pre-certification required
	<a href="#">Rehabilitation services</a>	No charge	See limits in SPD	Pre-certification required
	<a href="#">Habilitation services</a>	No charge	20% <a href="#">coinsurance</a>	Pre-certification required
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	Pre-certification required (Excludes Nursing Home)
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	Pre-cert required if cost exceeds \$500
	<a href="#">Hospice services</a>	Not covered	Not covered	---none---
If your child needs dental or eye care	Children’s eye exam	Not covered	Not covered	Covered by Optical plan
	Children’s glasses	Not covered	Not covered	Covered by Optical plan
	Children’s dental check-up	Not covered	Not covered	Covered by Optical plan

**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                          | • Infertility treatment                       | • Private-duty nursing                       |
| • Cosmetic surgery                     | • Long-term care                              | • Routine eye care (Covered by Optical Plan) |
| • Dental care (Covered by Dental Plan) | • Long-term acute care                        | • Routine foot care                          |
| • Gene therapy                         | • Out-of-Network non-emergency inpatient stay | • Weight loss programs                       |

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

- |                |                                   |
|----------------|-----------------------------------|
| • Bariatric    | • Hearing aids                    |
| • Chiropractic | • Routine foot care for diabetics |

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov). 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](http://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 questions about your rights, this notice, or assistance, call the **NOITU Member Services Dept. at 1-718-291-3434 option 3.**

**Does this Coverage Provide Minimum Essential Coverage? Yes**

This [plan](#) does provide [Minimum Essential Coverage](#). 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 Coverage Meet the Minimum Value Standard? Yes**

This health coverage does meet the [Minimum Value Standards](#) for the benefits it provides. 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:**

Para obtener asistencia en Español, llame al **Departamento de Servicios de Membresía de NOITU al 1-718-291-3434, opción 3.**

*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 \[Copayment\]](#) \$20
- Hospital (facility) [[Coinsurance](#)] 0%
- Other [[cost sharing](#)] 0%

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$130</b>

**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 \[Copayment\]](#) \$20
- Hospital (facility) [[Coinsurance](#)] 0%
- Other [[cost sharing](#)] 0%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$780
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$840</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[Copayment\]](#) \$20
- Hospital (facility) [[Copayment](#)] \$50
- Other [[cost sharing](#)] 0%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$150
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$150</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.