# NOITU Insurance Trust Fund: Gold Plan-$7.50/$30/$50

**Coverage Period: 1/1/2023-12/31/2023**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for: Individual and Family| Plan Type: PPO**

**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 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 or call 1-718-291-3434 option 3 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$600** per person/**$1,200** per family for in-network services | Generally, you must pay all of the costs from provider 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 deductibles?** | Yes, preventive care is covered before you meet your deductible | This plan covers some items and services if you haven't 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 deductible for specific services?** | Yes, **$1,200** per person/ **$2,400** per family for out-of-network services | You must pay all of the cost for these services (out-of-network) up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Yes, **$2,000** per person/ **$4,000** per family for in-network<br>**$1,600** per person/**$3,200** per family for prescription drugs<br>None for out-of-network | The out-of-pocket limit 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 out-of-pocket limit until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Copayments for certain services, Premiums, balance-billed charges, and health care charges 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 preferred providers see: **Empireblue.com** or call 1-800-810-2583 | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of the 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 providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |

| | | |
|---|---|---|
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without permission from this plan. |

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 In-network Provider (You will pay the least) | Your cost if you use an Out-of-network Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 10% coinsurance | 30% coinsurance | ---none--- |
| | Specialist visit | 10% coinsurance | 30% coinsurance | ---none--- |
| | Preventive care/screening/immunization | No charge | 30% coinsurance | ---none--- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance | ---none--- |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | Pre-certification required (See Summary Plan Description for details) |
| **If you need drugs to treat your illness or condition**<br><br>**For more information about your prescription drug coverage call CVS Caremark at 1-888-202-1654** | Generic drugs | $7.50 copay | $7.50 copay | See Summary Plan Description for details |
| | Preferred brand drugs | $30 copay | $30 copay | See Summary Plan Description for details |
| | Non-preferred brand drugs | $50 copay | $50 copay | See Summary Plan Description for details |
| | Specialty drugs | $7.50/$30/$50 copay for generic/preferred brand/ non-preferred brand | $7.50/$30/$50 copay 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) | 10% coinsurance | See limits in SPD | Pre-certification required |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | ---none--- |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider (You will pay the least) | Your cost if you use an Out-of-network Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $200 copay/visit | $200 copay/visit See limits in SPD | ---none--- |
| | Emergency medical transportation (Ground) | 10% coinsurance or balance after Fund pays $800 | 30% coinsurance or balance after Fund pays $800 | See Summary Plan Description for details re: air or sea |
| | Urgent care | 10% coinsurance | 30% coinsurance | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | Not covered | Pre-certification required |
| | Physician/surgeon fee | 10% coinsurance | 30% coinsurance | ---none--- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% coinsurance | 30% coinsurance | ---none--- |
| | Inpatient services | 10% coinsurance | See limits in SPD | Pre-certification required |
| **If you are pregnant** | Office visits | 10% coinsurance | 30% coinsurance | ---none--- |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | ---none--- |
| | Childbirth/delivery facility services | 10% coinsurance | See limits in SPD | Pre-certification required |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance | Pre-certification required |
| | Rehabilitation services | 10% coinsurance | See limits in SPD | Pre-certification required |
| | Habilitation services | 10% coinsurance | 30% coinsurance | Outpatient Only |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | Pre-certification required [Excludes Nursing Home] |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | Pre-cert required if cost exceeds $500 |
| | Hospice services | 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 Dental 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
- Cosmetic surgery
- Dental care (Covered by Dental Plan)
- Gene therapy
- Infertility treatment
- Long-term care
- Long-term acute care
- Out-of-Network non-emergency inpatient stay
- Private-duty nursing
- Routine eye care (Covered by Optical Plan)
- Routine foot care
- Weight loss programs

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

- Bariatric
- Chiropractic
- Hearing aids
- 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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 | $600 |
| Specialist *[Coinsurance]* | 10% |
| Hospital (facility) *[Coinsurance]* | 10% |
| Other *[cost sharing]* | 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 | $600 |
| Copayments | $30 |
| Coinsurance | $1,260 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,950** |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist *[Coinsurance]* | 10% |
| Hospital (facility) *[Coinsurance]* | 10% |
| Other *[cost sharing]* | 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 | $600 |
| Copayments | $620 |
| Coinsurance | $290 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,570** |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist *[Coinsurance]* | 10% |
| Hospital (facility) *[Coinsurance]* | 10% |
| Other *[cost sharing]* | 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 | $600 |
| Copayments | $0 |
| Coinsurance | $190 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$790** |

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