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?	**$ 1,000** per person **/$2,000** 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, **$2,000** per person/ **$4,000** 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, **$5,000** per person/ **$10,000** per family for in-network **$1,600** per person**/$3,200** per family for prescription drugs 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	20% coinsurance	40% coinsurance	---none---
	Specialist visit	20% coinsurance	40% coinsurance	---none---
	Preventive care/screening/immunization	No charge	40% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Pre-certification required (See Summary Plan Description for details)
If you need drugs to treat your illness or condition **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)	20% coinsurance	See limits in SPD	Pre-certification required
	Physician/surgeon fees	20% coinsurance	40% 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	$250 copay/visit	$250 copay/visit See limits in SPD	---none---
	Emergency medical transportation (Ground)	20% coinsurance or balance after Fund pays $800	40% coinsurance or balance after Fund pays $800	See Summary Plan Description for details re: air or sea
	Urgent care	20% coinsurance	40% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-certification required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	---none---
	Inpatient services	20% coinsurance	See limits in SPD	Pre-certification required
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	---none---
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	---none---
	Childbirth/delivery facility services	20% coinsurance	See limits in SPD	Pre-certification required
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Pre-certification required
	Rehabilitation services	20% coinsurance	See limits in SPD	Pre-certification required
	Habilitation services	20% coinsurance	40% coinsurance	Outpatient Only
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-certification required [Excludes Nursing Home]
	Durable medical equipment	20% coinsurance	40% 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	**$1,000**
■ **Specialist *[Coinsurance]***	**20%**
■ **Hospital (facility) *[Coinsurance]***	**20%**
■ **Other *[cost sharing]***	**20%**

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	$1,000
Copayments	$30
Coinsurance	$2,520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,610**

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

■ **The plan's overall deductible**	**$1,000**
■ **Specialist *[Coinsurance]***	**20%**
■ **Hospital (facility) *[Coinsurance]***	**20%**
■ **Other *[cost sharing]***	**20%**

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	$1,000
Copayments	$620
Coinsurance	$580
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$2,280**

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

■ **The plan's overall deductible**	**$1,000**
■ **Specialist *[Coinsurance]***	**20%**
■ **Hospital (facility) *[Coinsurance]***	**20%**
■ **Other *[cost sharing]***	**20%**

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	$1,000
Copayments	$0
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,280**

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