



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, see [www.ibatpa.com](http://www.ibatpa.com). 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-755-4414 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>Tier 1 (NWD):</b> \$0 individual / \$0 family <b>Tier 2 (BCBS):</b> \$500 individual / \$2,000 family <b>Out-of-Network:</b> \$1,000 individual / \$2,000 family	Generally, you must pay all of the costs from <a href="#">providers</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> (Embedded). Tier 2 applies to Tier 1 & Tier 2. Tier 1 only applies to Tier 1.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Tier 2 Preventative Care and Office visits are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet 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?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Tier 1 (NWD) &amp; Tier 2 (BCBS):</b> \$6,000 individual / \$18,200 family <b>Out-of-Network:</b> \$9,200 individual / \$18,200 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met (Embedded). Tier 1 and Tier 2 amounts are combined. Prescription drug costs apply to the medical out-of-pocket.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, and health care this plan does not 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. <b>TIER 1:</b> See <a href="http://www.ibatpa.com">www.ibatpa.com</a> for a list of participating providers in the <b>Northwell Direct</b> network. <b>TIER 2:</b> See <a href="http://www.Anthem.com">www.Anthem.com</a> for a list of participating providers or call 1-888-755-4414 for a list of participating providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

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 a <a href="#">referral</a> .
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Common Medical Event	Services You May Need	What Will You Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (NWD) Provider (You will pay the least)	Tier 2 (BCBS) Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	\$35 copay/visit	Deductible then 30% coinsurance	Virtual Care via CirrusMD at no charge or limitation to use at my.cirrusmd.com
	<a href="#">Specialist</a> visit	\$40 copay/visit	\$50 copay/visit	Deductible then 30% coinsurance	Virtual Care via CirrusMD at no charge or limitation to use at my.cirrusmd.com
	<a href="#">Preventive care/screening</a> /immunization	No charge	No charge	Deductible then 30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Minor Services: \$40 copay/visit Radiology: \$50 copay/visit	Minor Services: Deductible then \$50 copay/visit Radiology: Deductible then \$75 copay/visit	Deductible then 30% coinsurance	Minor Services include labs, ultrasounds, bone density tests, & echography.
	Imaging (CT/PET scans, MRIs)	\$400 copay/visit	Deductible then \$600 copay/visit	Deductible then 30% coinsurance	Pre-certification is required.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.carelonrx.com</a>	Generic drugs (Tier 1)	Retail: \$10 copay/prescription Mail Order: \$30 copay/prescription		Not covered	Injectable drugs are subject to 30% coinsurance.
	Preferred brand drugs (Tier 2)	Retail: \$50 copay/prescription Mail Order: \$150 copay/prescription		Not covered	Injectable drugs are subject to 30% coinsurance.
	Non-preferred brand drugs (Tier 3)	Retail: \$80 copay/prescription Mail Order:		Not covered	Injectable drugs are subject to 30% coinsurance.

Common Medical Event	Services You May Need	What Will You Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (NWD) Provider (You will pay the least)	Tier 2 (BCBS) Provider	Out-of-Network Provider (You will pay the most)	
		\$240 copay/prescription			
	<a href="#">Specialty drugs</a> (Tier 4)	Not covered			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 copay/visit	Deductible then \$1,000 copay/visit	Deductible then 30% coinsurance	Pre-certification is required for some surgical procedures. Please contact IBA at 878-222-4409 for additional information.
	Physician/surgeon fees	\$500 copay/visit	Deductible then \$1,000 copay/visit	Deductible then 30% coinsurance	Surgery done in the office will be subject to the PCP/Specialist office copay. Copay applies to facility, surgeon, and anesthesia charges.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$600 copay/visit	\$600 copay/visit	\$600 copay/visit	Copay will be waived if admitted. All professional fees billed during visit are covered at 100%.
	<a href="#">Emergency medical transportation</a>	\$600 copay/visit	\$600 copay/visit	\$600 copay/visit	
	<a href="#">Urgent care</a>	\$50 copay/visit	\$75 copay/visit	Deductible then 30% coinsurance	Copay will apply on the facility charge only.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay/admission	Deductible then \$1,000 copay/admission	Deductible then 30% coinsurance	Pre-certification is required.
	Physician/surgeon fee	Physician: \$40 copay/visit Surgeon: \$500 copay/visit	Physician: Deductible then \$50 copay/visit Surgeon: Deductible then \$1,000 copay/visit	Deductible then 30% coinsurance	Physician benefit includes all inpatient professional treatment.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay/visit	Deductible then \$50 copay/visit	Deductible then 30% coinsurance	Includes Intensive outpatient Therapy and Partial Hospitalization. Office setting will not be subject to deductible (Tier 2).

Common Medical Event	Services You May Need	What Will You Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (NWD) Provider (You will pay the least)	Tier 2 (BCBS) Provider	Out-of-Network Provider (You will pay the most)	
	Inpatient services	Facility: \$500 copay/admission Professional: \$40 copay/visit	Facility: Deductible then \$1,000 copay/admission Professional: Deductible then \$50 copay/visit	Deductible then 30% coinsurance	Pre-certification is required. Includes Residential Treatment facility.
If you are pregnant	Office visits	\$25 copay/visit	\$35 copay/visit	Deductible then 30% coinsurance	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). 1st prenatal visit will apply copay. All remaining routine visits are covered at 100%.
	Childbirth/delivery professional services	\$40 copay/visit	Deductible then \$50 copay/visit	Deductible then 30% coinsurance	
	Childbirth/delivery facility services	\$500 copay/admission	Deductible then \$1,000 copay/admission	Deductible then 30% coinsurance	Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a claim denial.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$40 copay/visit	Deductible then \$50 copay/visit	Deductible then 30% coinsurance	Pre-certification is required. Limited to 40 visits per year.
	<a href="#">Rehabilitation services</a>	\$40 copay/visit	Deductible then \$50 copay/visit	Deductible then 30% coinsurance	Pre-certification is required. Limited to 50 visits per year combined with physical, occupational, and speech therapies.
	<a href="#">Habilitation services</a>	\$40 copay/visit	Deductible then \$50 copay/visit	Deductible then 30% coinsurance	Pre-certification is required. Limited to 50 visits per year combined with physical, occupational, and speech therapies.

Common Medical Event	Services You May Need	What Will You Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (NWD) Provider (You will pay the least)	Tier 2 (BCBS) Provider	Out-of-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	\$500 copay/admission	Deductible then \$1,000 copay/admission	Deductible then 30% coinsurance	Pre-certification is required.
	<a href="#">Durable medical equipment</a>	\$400 copay/device	Deductible then \$500 copay/device	Deductible then 30% coinsurance	Pre-certification is required for items over \$1,000 purchase price.
	<a href="#">Hospice services</a>	\$500 copay/admission	Deductible then \$1,000 copay/admission	Deductible then 30% coinsurance	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Deductible then 30% coinsurance	For vision exams during a well visit with pediatrician according to ACA guidelines.
	Children's glasses	No charge	No charge	Not covered	
	Children's dental check-up	No charge	No charge	Not covered	

#### 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](#).)**

<ul style="list-style-type: none"> <li>• Abortion (elective)</li> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids</li> <li>• Infertility Treatment</li> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty Nursing</li> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>
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**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.)**

<ul style="list-style-type: none"> <li>• Chiropractic Care (Limited to 30 visits per year)</li> </ul>		
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**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](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 on how 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 plan at 1-888-755-4414. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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](#).

*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 Tier 1 pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network Tier 2 care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care Tier 1)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Primary Care</a> [ <a href="#">Copay</a> ]	\$25	■ <a href="#">Specialist</a> [ <a href="#">Copay</a> ]	\$50	■ <a href="#">Specialist</a> [ <a href="#">Copay</a> ]	\$40
■ Hospital (facility) [ <a href="#">copay</a> ]	\$500	■ Hospital (facility) [ <a href="#">copay</a> ]	\$1000	■ Hospital (facility) [ <a href="#">copay</a> ]	\$500
■ Other [ <a href="#">coinsurance</a> ]	0%	■ Other [ <a href="#">coinsurance</a> ]	0%	■ Other [ <a href="#">coinsurance</a> ]	0%
This EXAMPLE event includes services like: <a href="#">Primary Care</a> office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> ) <a href="#">Specialist</a> visit ( <i>anesthesia</i> )		This EXAMPLE event includes services like: <a href="#">Primary care physician</a> office visits ( <i>including disease education</i> ) <a href="#">Diagnostic tests</a> ( <i>blood work</i> ) <a href="#">Prescription drugs</a> <a href="#">Durable medical equipment</a> ( <i>glucose meter</i> )		This EXAMPLE event includes services like: <a href="#">Emergency room care</a> ( <i>including medical supplies</i> ) <a href="#">Diagnostic test</a> ( <i>x-ray</i> ) <a href="#">Durable medical equipment</a> ( <i>crutches</i> ) <a href="#">Rehabilitation services</a> ( <i>physical therapy</i> )	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<a href="#">Deductibles</a>	\$0	<a href="#">Deductibles</a>	\$500	<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1145	<a href="#">Copayments</a>	\$1090	<a href="#">Copayments</a>	\$1580
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$1145	The total Joe would pay is	\$1590	The total Mia would pay is	\$1580