



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. 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 or call 1-888-755-4414 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	Tier 1 (NWD): \$2,000 individual / \$4,000 family Tier 2 (BCBS): \$3,000 individual / \$6,000 family Out-of-Network: \$6,000 individual / \$12,000 family	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 total amount of deductible expenses paid by all family members meets the overall family deductible (Embedded). Tier 2 applies to Tier 1 & Tier 2. Tier 1 only applies to Tier 1.
Are there services covered before you meet your deductible?	Yes. Preventive care and office visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet 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 deductibles for specific services?	Yes. Prescription drugs \$150 individual / \$300 family.	You must pay up to the deductible amount before this plan begins to pay.
What is the out-of-pocket limit for this plan?	Tier 1 (NWD) & Tier 2 (BCBS): \$7,500 individual / \$18,200 family Out-of-Network: \$9,200 individual / \$18,200 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not 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. TIER 1: See www.ibatpa.com for a list of participating providers in the Northwell Direct network. TIER 2: See www.anthem.com for a list of participating providers in the Anthem National BlueCard PPO network, or call 1-888-755-4414.	This 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 the provider's charge and what your plan pays (balance billing). Be aware, your network provider might 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 you choose without a referral.

What You Pay for Covered Services					
Common Medical Event	Services You May Need	What Will You Pay			Limitations, Exceptions & Other Important Information
		Tier 1 – Northwell Direct (You will pay the least)	Tier 2 – Anthem National BlueCard PPO	Out-of-Network (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	\$35 copay/visit	\$40 copay/visit	Deductible then 40% coinsurance	Virtual Care via CirrusMD at no charge or limitation to use at my.cirrusmd.com
	Specialist visit	\$45 copay/visit	\$55 copay/visit	Deductible then 40% coinsurance	Virtual Care via CirrusMD at no charge or limitation to use at my.cirrusmd.com
	Preventive care/screening/immunization	No charge	No charge	Deductible then 40% 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	Diagnostic test (x-ray, blood work)	Minor Services: Deductible then \$45 copay/visit Radiology: Deductible then \$100 copay/visit	Minor Services: Deductible then \$55 copay/visit Radiology: Deductible then \$125 copay/visit	Deductible then 40% coinsurance	Minor Services include labs, ultrasounds, bone density tests, and echography.
	Imaging (CT/PET scans, MRIs)	Deductible then \$600 copay/visit	Deductible then \$1,000 copay/visit	Deductible then 40% coinsurance	Pre-certification is required.
If you need drugs to treat your illness or condition More information at www.carelonrx.com	Generic drugs (Tier 1)	Retail: \$10 copay/prescription Mail Order: \$30 copay/prescription		Not covered	Rx deductible does not apply to generics. Injectable drugs are subject to 30% coinsurance.
	Preferred brand drugs (Tier 2)	Retail: Deductible then \$60 copay/prescription Mail Order: Deductible then \$180 copay/prescription		Not covered	Rx deductible applies prior to copay: \$150 individual / \$300 family. Injectable drugs are subject to 30% coinsurance.
	Non-preferred brand drugs (Tier 3)	Retail: Deductible then \$80 copay/prescription Mail Order: Deductible then \$240 copay/prescription		Not covered	Rx deductible applies prior to copay: \$150 individual / \$300 family. Injectable drugs are subject to 30% coinsurance.
	Specialty drugs (Tier 4)	Not covered		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then \$700 copay/visit	Deductible then \$1,000 copay/visit	Deductible then 40% coinsurance	Pre-certification is required for some surgical procedures. Please contact IBA at 878-222-4409 for additional information.
	Physician/surgeon fees	Deductible then \$700 copay/visit	Deductible then \$1,000 copay/visit	Deductible then 40% 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	Emergency room care	Deductible then \$800 copay/visit	Deductible then \$800 copay/visit	Deductible then \$800 copay/visit	Copay will be waived if admitted. All professional fees billed during the visit are subject to deductible only.
	Emergency medical transportation	Deductible then \$700 copay/visit	Deductible then \$700 copay/visit	Deductible then \$700 copay/visit	
	Urgent care	\$75 copay/visit	\$95 copay/visit	Deductible then 40% coinsurance	Copay will apply on the facility charge only.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then \$700 copay/admission	Deductible then \$1,000 copay/admission	Deductible then 40% coinsurance	Pre-certification is required.
	Physician/surgeon fee	Physician: Deductible then \$45 copay/visit Surgeon: Deductible then \$700 copay	Physician: Deductible then \$55 copay/visit Surgeon: Deductible then \$1,000 copay	Deductible then 40% coinsurance	Benefit includes all inpatient professional treatment.

Common Medical Event	Services You May Need	What Will You Pay			Limitations, Exceptions & Other Important Information
		Tier 1 – Northwell Direct (You will pay the least)	Tier 2 – Anthem National BlueCard PPO	Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible then \$45 copay/visit	Deductible then \$55 copay/visit	Deductible then 40% coinsurance	Includes Intensive Outpatient Therapy and Partial Hospitalization. Office setting will not be subject to deductible.
	Inpatient services	Facility: Deductible then \$700 copay/admission Professional: Deductible then \$45 copay/visit	Facility: Deductible then \$1,000 copay/admission Professional: Deductible then \$55 copay/visit	Deductible then 40% coinsurance	Pre-certification is required. Includes Residential Treatment facility.
If you are pregnant	Office visits	\$35 copay/visit	\$40 copay/visit	Deductible then 40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound). 1st prenatal visit will apply copay. All remaining routine visits are covered at 100%.
	Childbirth/delivery professional services	Deductible then \$45 copay/visit	Deductible then \$55 copay/visit	Deductible then 40% coinsurance	
	Childbirth/delivery facility services	Deductible then \$700 copay/admission	Deductible then \$1,000 copay/admission	Deductible then 40% 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	Home health care	Deductible then \$70 copay/visit	Deductible then \$95 copay/visit	Deductible then 40% coinsurance	Pre-certification is required. Limited to 40 visits per year.
	Rehabilitation services	Deductible then \$55 copay/visit	Deductible then \$75 copay/visit	Deductible then 40% coinsurance	Pre-certification is required. Limited to 50 visits per year combined with physical, occupational, and speech therapies.
	Habilitation services	Deductible then \$55 copay/visit	Deductible then \$75 copay/visit	Deductible then 40% coinsurance	Pre-certification is required. Limited to 50 visits per year combined with physical, occupational, and speech therapies.
	Skilled nursing care	Deductible then \$700 copay/admission	Deductible then \$1,000 copay/admission	Deductible then 40% coinsurance	Pre-certification is required.
	Durable medical equipment	Deductible then \$350 copay/device	Deductible then \$500 copay/device	Deductible then 40% coinsurance	Pre-certification is required for items over \$1,000 purchase price.
	Hospice services	Deductible then \$700 copay/admission	Deductible then \$1,000 copay/admission	Deductible then 40% coinsurance	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Deductible then 40% 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.)

• Abortion (elective)	• Acupuncture	• Bariatric Surgery
• Cosmetic Surgery	• Dental Care (Adult)	• Hearing Aids
• Infertility Treatment	• Long Term Care	• Non-emergency care when traveling outside the U.S.
• Private-duty Nursing	• Routine Eye Care (Adult)	• Routine Foot Care
• Weight Loss Programs		

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.

• Chiropractic Care (Limited to 30 visits per year)		
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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. 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 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.

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.

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)	
▪ The plan's overall deductible	\$2,000
▪ Primary Care [Copay]	\$35
▪ Hospital (facility) [copay]	\$700
▪ Other [coinsurance]	n/a
This EXAMPLE event includes services like: Primary Care office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)	
Total Example Cost	\$12,700
Cost Sharing	
Deductibles	\$2,000
Copayments	\$1,570
Coinsurance	\$0
Limits or exclusions	\$0
The total would be	\$3,570

Managing Joe's Type 2 Diabetes (a year of routine in-network Tier 2 care of a well-controlled condition)	
▪ The plan's overall deductible	\$3,000
▪ Specialist [Copay]	\$55
▪ Hospital (facility) [copay]	\$1,000
▪ Other [coinsurance]	n/a
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	\$5,600
Cost Sharing	
Deductibles	\$3,150
Copayments	\$2,450
Coinsurance	\$0
Limits or exclusions	\$0
The total would be	\$5,600

Mia's Simple Fracture (in-network Tier 1 emergency room visit and follow up care)	
▪ The plan's overall deductible	\$2,000
▪ Specialist [Copay]	\$45
▪ Hospital (facility) [copay]	\$700
▪ Other [coinsurance]	n/a
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	\$2,800
Cost Sharing	
Deductibles	\$2,000
Copayments	\$800
Coinsurance	\$0
Limits or exclusions	\$0
The total would be	\$2,800