Inlandboatmen's Union – Trust Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 1/1/21-12/31/21
Coverage for: Employee/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 go to www.ibubenefits.org or call 1-800-547-4457 (outside Portland) or 1-503-224-0048. 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.ibubenefits.org or call the numbers above to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Per claimant/Per family per plan year: Medical-PPO Providers: **$200/$600** Medical-Non-PPO Providers: **$500/$1,000**	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	**Yes.**	Deductible waived for preventive care, office visits, and acupuncture, chiropractic and naturopathic care from in-network providers.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Per claimant/ Per family per plan year: Medical-PPO providers: **$1,700/$3,600**. Medical Non-PPO Providers: **$5,000/$10,000** Prescription Drug: **$4,900/$9,600**	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Any amounts you pay for **non-covered services, or amounts in excess of the allowed amount** do not apply toward the out-of-pocket limit.	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. See www.premera.com or call **1-800-810-2583** for lists of preferred or participating providers.	If you use an in–network doctor or other health care provider, this plan will pay some or all of the costs of 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 for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.

* For more information about limitations and exceptions, see the plan or policy document at www.ibubenefits.org. You may also call (503) 224-0048, ext. 161 or toll free (800) 547-4457, ext. 1651.

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Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (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	**$20** copay	**40%** coinsurance/visit	**Co–payment** applies to each in-network office visit only**.** All other services are covered at the coinsurance specified after deductible**.**
	Specialist visit	**$20** copay	**40%** coinsurance/visit	
	Preventive care/screening/ immunization	No charge	**40%** coinsurance/visit	No charge for childhood immunizations from in-network providers. Deductible waived for preventive care from in-network providers.
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	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.modahealth/mymoda or by calling 1-800-913-4311. For mail order www.ppsrx.com or by calling 1-800-552-6694.	Generic drugs	**$10** copay retail **$20** copay mail-order	**Not Covered**	Certain prescription drugs require prior authorization from MODA before the prescription drug may be dispensed. All specialty medications must be obtained through Ardon Specialty Pharmacy. **Please contact 855-425-4085 or www.ardonhealth.com** for more information on specialty medications.
	Preferred brand drugs	**$20** copay retail **$40** copay mail-order	**Not Covered**	
	Non-preferred brand drugs	**$40** copay retail **$80** copay mail-order	**Not Covered**	
	Specialty drugs	Refer to generic, preferred brand and non–preferred brand drugs above.	**Not Covered**	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**20%** coinsurance	**40%** coinsurance	**Preauthorization for Out-of-Network Providers and Facilities Recommended**
	Physician/surgeon fees	**20%** coinsurance	**40%** coinsurance	**Preauthorization for Out-of-Network Providers and Facilities Recommended**
If you need immediate medical attention	Emergency room care	**20%** coinsurance	**20%** coinsurance	——————none——————
	Emergency medical transportation	**20%** coinsurance	**20%** coinsurance	——————none——————
	Urgent care	Covered the same as any other illness or condition.		——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**20%** coinsurance	**40%** coinsurance	**Preauthorization for Out-of-Network Providers and Facilities Recommended**
	Physician/surgeon fees	**20%** coinsurance	**40%** coinsurance	**Preauthorization for Out-of-Network Providers and Facilities Recommended**
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**$20** copayment/office visit **20%** coinsurance for other outpatient services	**40%** coinsurance	——————none——————
	Inpatient services	**20%** coinsurance	**40%** coinsurance	**Preauthorization for Out-of-Network Providers and Facilities Recommended**
If you are pregnant	Office visits	No charge	**40%** coinsurance	——————none——————
	Childbirth/delivery professional services	**20%** coinsurance	**40%** coinsurance	
	Childbirth/delivery facility services	**20%** coinsurance	**40%** coinsurance	
If you need help recovering or have other special health needs	Home health care	**20%** coinsurance	**40%** coinsurance	Limited to 100 visits per calendar year.
	Rehabilitation services	**20%** coinsurance	**40%** coinsurance	——————none——————
	Habilitation services	**20%** coinsurance	**40%** coinsurance	——————none——————
	Skilled nursing care	**20%** coinsurance	**40%** coinsurance	Limited to 30 days per calendar year.
	Durable medical equipment	**20%** coinsurance	**40%** coinsurance	——————none——————

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	**20%** coinsurance	**40%** coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	**20%** coinsurance	**20%** coinsurance	No calendar year limit on vision care for children up to age 19.
	Children's glasses	**20%** coinsurance	**20%** coinsurance	No calendar year limit on vision care for children up to age 19.
	Children's dental check-up	**20%** coinsurance	**20%** coinsurance	No calendar year limit on dental care for children up to age 19. Maximum of 2 routine exams per year.

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.)

- Cosmetic surgery, except congenital anomalies and as required by Women's Health and Cancer Rights Act
- Long-term care
- Private-duty nursing
- Hearing aids (cochlear implants are covered)
- Infertility treatment
- Routine foot care except for diabetic patients
- Weight loss programs except for nutritional counseling

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

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Dental Care (Adult)
- Care when traveling outside the U.S.
- Routine Eye Care (Adult)

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: (503) 224-0048, ext. 1651 or toll free (800) 547-4457, ext. 1651. 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: (503) 224-0048, ext. 1651 or toll free (800) 547-4457, ext. 1651.

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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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al (503) 224-0048, ext. 1651 or toll free (800) 547-4457, ext. 1651

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (503) 224-0048, ext. 1651 or toll free (800) 547-4457, ext. 1651

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(503) 224-0048, ext. 1651 or toll free (800) 547-4457, ext. 1651

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (503) 224-0048, ext. 1651 or toll free (800) 547-4457, ext. 1651

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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	$200
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,760**

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	$111
Hospital (facility) *[cost sharing]*	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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	$111
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$710**

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

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