

# Inlandboatmen's Union – Trust Plan

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

Coverage Period: 1/1/26-12/31/26

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](http://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](http://www.ibubenefits.org) or call the numbers above to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Per claimant/Per family per <a href="#">plan</a> year: Medical-PPO Providers: <b>\$200/\$600</b> Medical-Non-PPO Providers: <b>\$500/\$1,000</b>	You must pay all the costs up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for covered services you use. Check your policy or <a href="#">plan</a> document to see when the <a href="#">deductible</a> 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 <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b>	<a href="#">Deductible</a> waived for <a href="#">preventive care</a> , office visits, and acupuncture, chiropractic and naturopathic care from in-network <a href="#">providers</a> .
Are there other <a href="#">deductibles</a> for specific services?	No. There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services, but see the chart starting on page 2 for other costs for services this <a href="#">plan</a> covers.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Per claimant/ Per family per <a href="#">plan</a> year: Medical-PPO providers: <b>\$1,700/\$3,600</b> . Medical Non-PPO Providers: <b>\$5,000/\$10,000</b> Prescription Drug: <b>\$4,900/\$9,600</b>	The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limit</a> ?	Any amounts you pay for <b>non-covered services, or amounts in excess of the allowed amount</b> do not apply toward the <a href="#">out-of-pocket limit</a> .	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. See <a href="http://www.premiera.com">www.premiera.com</a> or call <b>1-800-810-2583</b> for lists of preferred or participating <a href="#">providers</a> .	If you use an in-network doctor or other health care <a href="#">provider</a> , this <a href="#">plan</a> will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an <a href="#">out-of-network provider</a> for some services. <a href="#">Plans</a> use the term in-network, preferred, or participating for <a href="#">providers</a> in their <a href="#">network</a> . See the chart starting on page 2 for how this <a href="#">plan</a> pays different kinds of <a href="#">providers</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ibubenefits.org](http://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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No. You don't need a referral to see a <a href="#">specialist</a> .	You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</a> .

 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a>	40% <a href="#">coinsurance</a> /visit	<a href="#">Co-payment</a> applies to each in-network office visit only. All other services are covered at the <a href="#">coinsurance</a> specified after <a href="#">deductible</a> .
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a>	40% <a href="#">coinsurance</a> /visit	
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a> /visit	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
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.modahealth.com/memberdashboard</a> (800-913-4311).	Generic drugs	\$10 <a href="#">copay</a> retail \$20 <a href="#">copay</a> mail-order	Not Covered	Certain <a href="#">prescription drugs</a> require prior authorization from MODA before the prescription drug may be dispensed. All specialty medications must be obtained through Ardon Health Specialty Pharmacy. <b>Please contact 855-425-4085 or <a href="#">www.ardonhealth.com</a></b> for more information on specialty medications.  For mail order: <a href="#">www.ppsrx.com</a> (800-552-6694) or <a href="#">pharmacy.costco.com</a> (800-607-6861)
	Preferred brand drugs	\$20 <a href="#">copay</a> retail \$40 <a href="#">copay</a> mail-order	Not Covered	
	Non-preferred brand drugs	\$40 <a href="#">copay</a> retail \$80 <a href="#">copay</a> mail-order	Not Covered	
	<a href="#">Specialty drugs</a>	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% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Preauthorization for <a href="#">Out-of-Network Providers</a> and Facilities Recommended
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Preauthorization for <a href="#">Out-of-Network Providers</a> and Facilities Recommended
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	_____none_____
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	_____none_____
	<a href="#">Urgent care</a>	Covered the same as any other illness or condition.		_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> for <a href="#">Out-of-Network Providers</a> and Facilities Recommended
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> for <a href="#">Out-of-Network Providers</a> and Facilities Recommended
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copayment</a> /office visit 20% <a href="#">coinsurance</a> for other outpatient services	40% <a href="#">coinsurance</a>	_____none_____
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> for <a href="#">Out-of-Network Providers</a> and Facilities Recommended
If you are pregnant	Office visits	No charge	40% <a href="#">coinsurance</a>	_____none_____
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 100 visits per calendar year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	_____none_____
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	_____none_____
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 30 days per calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	_____none_____

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
If your child needs dental or eye care	Children's eye exam	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	No calendar year limit on vision care for children up to age 19.
	Children's glasses	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	No calendar year limit on vision care for children up to age 19.
	Children's dental check-up	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Cosmetic surgery, except congenital anomalies and as required by Women's Health and Cancer Rights Act</li> <li>Long-term care</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (cochlear implants are covered)</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care except for diabetic patients</li> <li>Weight loss programs except for nutritional counseling</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Care when traveling outside the U.S.</li> <li>Routine Eye Care (Adult)</li> </ul>

**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](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: (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, kwijigo 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$200
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<a href="#">Copayments</a>	\$0
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<a href="#">Coinsurance</a>	\$1,500
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<i>What isn't covered</i>	
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Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$1,760</b>
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### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$200
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<a href="#">Copayments</a>	\$600
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<a href="#">Coinsurance</a>	\$200
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<i>What isn't covered</i>	
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Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$1,020</b>
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### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$200
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<a href="#">Copayments</a>	\$10
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<a href="#">Coinsurance</a>	\$500
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<i>What isn't covered</i>	
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Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$710</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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