Pipeline Industry Benefit Fund

HEALTH AND WELFARE PLAN BENEFITS

Summary Plan Description

PIBF

PIBF HEALTH PLAN BENEFITS

Summary Plan Description

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January 2019

As updated through July 2026

PIBF HEALTH PLAN BENEFITS

Summary Plan Description

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Physical Address:
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4845 S. 83rd East Avenue
Tulsa, Oklahoma 74145-6909

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P.O. Box 470950
Tulsa, Oklahoma 74147-0950

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(918) 280-4899 Health & Welfare

website:
www.pibf.org

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Board of Trustees

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Co-Chairman

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Board of Trustees Statement

THE PIPELINE INDUSTRY BENEFIT FUND IS A JOINT EFFORT BY THE SIGNATORY CONTRACTORS AND UNION TO PROVIDE HEALTH BENEFITS FOR EMPLOYEES PERFORMING WORK UNDER THE UNITED ASSOCIATION'S NATIONAL PIPE LINE AGREEMENT.

This presentation provides an outline of the health and welfare plan arranged for pipeline industry employees and their dependents – based on the latest Benefits, Claims Procedure Manual and Summary Plan Description.

The cost of the program is funded by employer contributions through negotiations with union pipeline contractors as provided by the agreement and declaration of the trust agreement, which established the Pipeline Industry Benefit Fund as well as any self-payments for COBRA or extended retiree coverage when available.

The health and welfare plan, known as the Pipeline Industry Benefit Plan (PIBF), is available to any eligible person without medical examination, regardless of age.

You are asked to read the information in this presentation carefully so that you may know your benefits and understand your eligibility.

To download a printable copy of the PIBF Benefits and Summary Plan Description booklet, go to our Web site at www.pibf.org.

We, the Board of Trustees of the Pipeline Industry Benefit Fund, declare that this booklet serves as the Plan document and Summary Plan Description (SPD). The Trustees have discretionary authority to resolve all questions concerning the administration, interpretation or application of the Plan. This includes without limitation discretionary authority to determine eligibility for benefits or to construe the terms of the Plan in conducting the review of any appeal.

The Plan Documents provide that the Board of Trustees of PIBF may amend, revise or terminate the Health and Welfare Plan as they deem necessary.

Any changes authorized will take effect on the date specified by the Board and will apply to all affected persons regardless of status, illness or injury sustained prior to the effective date. Eligibility and benefits are not guaranteed. In the event of Plan termination, the Board of Trustees will, within the limits of the Plan's resources, adopt a plan to discharge all outstanding obligations and provide that all remaining assets be used in a manner that best carries out the basic purpose for which the Plan was established or otherwise be disposed of in a manner consistent with applicable law.

Consultants to the Pipeline Industry Benefit Fund

Accounting Firm

RubinBrown, LLP
1200 Main Street
Suite 1000
Kansas City, MO 64105

Actuarial Consultant

Adam Condrick
Segal Consulting
1800 M Street, NW, Suite 900S
Washington, D.C. 20036

*Medical PPO Network**

Blue Cross Blue Shield of Illinois (BCBSIL)
300 E. Randolph
Chicago, IL 60601-5099
1-800-810-2583
www.bcbsil.com

*Dental PPO Network**

Dental Network of America (DNOA)
Two TransAm Plaza Drive, Suite 500
Oakbrook Terrace, IL 60181
1-866-522-6758
www.dnoa.com

*Pharmacy Plan Provider**

Sav-Rx Prescription Services
224 North Park Ave.
Fremont, NE 68025
1-800-228-3108
www.savrx.com

*To locate a participating provider, visit the network's website. A link is also available at www.pibf.org.

Pre-certification & Utilization Review Providers

Blue Cross Blue Shield of Illinois
300 E. Randolph St.
Chicago, IL 60601-5099
1-800-572-3089
www.bcbsil.com

Language Translation Services

Language Line Solutions
1 Lower Ragsdale Drive
Building 2
Monterey, CA 93940

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1111 Superior Ave., Ste. 2340
Cleveland, OH 44114

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1333 New Hampshire Avenue
Washington, D.C. 20036

Director's Statement

The Pipeline Industry Benefit Fund is a Taft Hartley trust fund group health plan regulated by ERISA. The Plan is a group health plan administered by the Board of Trustees, consisting of an equal number of Union and Employer representatives. The Board of Trustees may contract with outside parties to provide administrative services. Plan fiscal year ends December 31 of each calendar year; Plan #501; Tax ID #73-0742835.

All assets of the Plan are accumulated in the PIBF, which is a trust fund administered by the Board of Trustees. The Board of Trustees may appoint qualified investment advisors to assist with the investment of assets. All Plan benefits are payable solely out of the assets of the PIBF. The investments are managed in accordance with the Fund's investment policy.

Notice to all plan participants & beneficiaries

On Labor Day of 1974, a new law was enacted by President Ford to protect the interests of workers in pension and welfare benefits connected with their jobs. Its title is the "Employee Retirement Income Security Act of 1974," but it is often referred to by its initials – ERISA.

For more information on ERISA, please refer to the section "Statement of ERISA Rights."

ERISA requires plan administrators and the Board of Trustees of your welfare fund, to tell you facts that you need to know, in writing, and free of charge. The Trustees must also let you look at plan documents and buy copies of them at a reasonable cost if requested.

ERISA imposes duties upon the individuals who are responsible for the operation of this Plan. ERISA says that these individuals, called fiduciaries, must act solely in your interest and be prudent and responsible in carrying out their Plan duties. ERISA also has other special rules that limit what a fiduciary is allowed to do. Fiduciaries who violate ERISA may be removed and must make good any losses they cause to PIBF.

The Director is designated as the proper person upon whom service of process shall be made. The Fund office is located at 4845 South 83rd East Avenue, Tulsa, Oklahoma, 74145-6909. Service of legal process may also be made upon a plan Trustee.

The Pipeline Industry Benefit Fund encourages the use of the PPO networks and Centers of Excellence within the PPO networks. By obtaining medical or dental services from a network participating provider, both the member and the PIBF share in the savings. The discounts obtained vary by provider; however, in some cases, the savings can be substantial, which is an incentive for the PIBF members to make use of the networks available for both medical and dental services.

The Board of Trustees for the Pipeline Industry Benefit Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act.) As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Director
Renée Vause

Statement of ERISA Rights

PARTICIPANT'S RIGHTS

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

CONTINUE GROUP HEALTH PLAN COVERAGE

ENFORCE YOUR RIGHTS

PROTECTED HEALTH INFORMATION

ASSISTANCE WITH QUESTIONS

Participant's Rights

As a participant in Pipeline Industry Benefit Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund office and at other specified locations, such as worksites and union halls, all documents governing the Plan including insurance contracts, Collective Bargaining and Participation Agreements, and a copy of the latest annual report (Form 5500s) filed by the plan with the U.S. Department of Labor and are available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining and participation agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, or dependent spouse or children if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who shall pay court costs and legal fees. If you are successful in your lawsuit, the court may require the other party to pay your legal costs, including attorney's fees. If you are unsuccessful in your lawsuit, the court may order you to pay the costs and fees of PIBF as well as your own if, for example, the court decides that your claim is frivolous.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan by following the claims filing and Claims Appeal Procedure described in this booklet, before you may file suit in court. You will then have one year, from the date a final decision on the appeal is reached under the Plan, in which to start a lawsuit. In no event may legal action be brought in court, by you or on your behalf, later than this 1-year period.

You have the right to inquire of the PIBF office of information as to whether a particular employer or employee organization is covered by the collective bargaining agreement or participates in this health and welfare plan.

Protected Health Information

The Pipeline Industry Benefit Fund is committed to protecting its members and their families' Protected Health Information (PHI). One of the benefits of the Health Insurance Portability and Accountability Act, also known as HIPAA, is to safeguard your right to privacy in regard to personal or individual health information. This Act incorporates very specific regulations which monitor the way certain health information is shared by health plans and medical providers as well as health insurers.

The American Recovery and Reinvestment Act (ARRA) of 2018 includes the Health Information Technology for Economic and Clinical Health (HITECH) act.

The HITECH Act provides Medicare and Medicaid monetary incentives for hospitals and physicians to adopt electronic health records (EHRs) and provides grants for the development of a health information exchange (HIE).

ARRA describes improvements to existing HIPAA law, holding covered entities, business associates and others to more rigorous standards relating to protected health information (PHI).

The Pipeline Industry Benefit Fund has developed privacy and security policies and procedures to comply with HIPAA and the HITECH Act. These policies and procedures will affect not only PIBF staff, but also all contracted business associates such as attorneys, accountants, and consultants that assist the Plan. Your individual health information will not be used for any purpose other than to complete the processing of a claim or as permitted by HIPAA. The names or addresses of PIBF members will never be sold or used for any type of marketing practice or solicitation.

The privacy regulations also limit the amount of information the PIBF can provide to persons other than the individual or patient. The patient or individual can sign a form giving PIBF permission to provide personal health information to an authorized representative. This is not permanent authorization and can only be used for a specified time period or relating to a specified condition. If the individual or patient is under legal age, parents or legal guardians will be able to gain access to the claim information or personal health information of the child. The privacy rules are effective as of April 14, 2003. You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

In summary, your rights under HIPAA include the right to:

- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you would like a copy of the Plan's Privacy Notice, please contact the Fund Office. You may also read the complete Privacy Notice at www.pibf.org.

If you believe that your privacy or security rights have been violated or you are not satisfied with any answers you have received regarding a privacy or security issue, you may file a written complaint with the Plan's Privacy and Security Officer, or you may contact or file a complaint with the Secretary of the U.S. Department of Health and Human Services ("HHS"), Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20202. The Plan will not retaliate against you for filing a complaint.

If you have any questions regarding your privacy or security rights, you should contact the Plan's Privacy and Security Officer as follows:

Renée Vause, Director
P.O. Box 470950
Tulsa, Oklahoma 74147-0950
Phone: (918) 280-4800
Fax: (918) 280-4899
E-Mail: renee@pibf.org

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

Benefits & Summary Plan Description

ENROLLMENT IN THE PIBF HEALTH PLAN

FILING A CLAIM

CLAIMS APPEAL PROCEDURE

Enrollment in the PIBF Health Plan

You must provide the PIBF office with a completed Census Data form prior to or at the time you establish initial eligibility. A PIBF Census Data Form is available upon request from the PIBF office, job site (contact your job steward), or online at www.pibf.org. This form must be on file in order for PIBF to communicate with you and provide the benefits you and your qualified dependents are entitled to.

Important: You must notify PIBF of any change in status.

It is your responsibility to notify PIBF of any change in status whenever you change your:

- Home address
- Marital status
- Dependents
- Beneficiary
- Local union affiliation
- Eligibility for any other health care coverage for yourself or your dependents

Failure to notify PIBF of a status change could delay the processing of your claim, or your claim could be denied or processed incorrectly.

The PIBF member will be held responsible for reimbursement to the Fund office for any erroneous payments which are the result of their failure to notify PIBF of changes in their dependent's status.

To notify PIBF of any change in your status, fill out a new Census Form and send it to:

Pipeline Industry Benefit Fund
P.O. Box 470950
Tulsa, Oklahoma 74147-0950
Fax: 918-280-4899

Filing a Claim

A claim is a request for a benefit made by a claimant or provider in accordance with the Fund's claims procedures. In network, or PPO claims should always be filed by the Provider. Direct claim submission is part of the agreement or contract that a PPO provider has with BCBSIL which maintains the PPO Network in which the Plan currently participates. In addition, when PIBF processes a PPO claim, payment issued to the provider is done through BCBS on behalf of the Pipeline Industry Benefit Fund. In most cases, it will not be necessary for you to fill out claim forms. In the event a claim form is needed, you will receive correspondence from the PIBF office advising you of the additional information needed to process your claim.

- Upon presentation of your medical ID card, with the BCBS PPO logo, the Provider's office should file with their local BCBS office.
- If your coverage with PIBF is secondary to Medicare, CMS will submit claims to the PIBF office through the Medicare Crossover program on the participant's behalf.
- Non-PPO claims that you have paid can be mailed to the PIBF office. When reimbursement is being issued to the member, a paid receipt must accompany the itemized statement of service rendered and claim form.

Whether the claim is a PPO claim or a Non-PPO claim, the following information should always be included:

1. Patient's full name
2. Name of policyholder (i.e., PIBF member)
3. Member's UID number
4. Date of service
5. Diagnosis
6. Procedure codes for services rendered
7. Complete name and mailing address of the provider of service

A request about whether an individual is generally eligible for benefits under the Plan is not a claim. Casual inquiries about benefits or the circumstances under which benefits might be paid under the terms of the Plan are not considered claims.

Notice & Proof of Loss – When You Should File a Claim

Claims for all medical expenses and related information must be furnished in writing to PIBF within one year (365 days) from the date incurred (i.e., the date of service or date furnished.) Claims submitted after this time period will be denied.

Loss of Time – Disability Benefits and Disability Claims

To receive disability benefits, written notice of disability must be submitted to the Fund office within 90 days of the first day of disablement. To continue receiving benefits, applications can be made bi-weekly or monthly, and information regarding treatment is required from the employee's physician. When the determination of disability is made by PIBF based on the medical evidence and not by a party other than PIBF for non-PIBF purposes, the claim for disability benefits will be referred to as a "Disability Claim."

Definition of an Adverse Benefit Determination

An Adverse Benefit Determination is any denial, reduction, termination of or failure to provide or make payment for a benefit (either whole or in part). For a Disability Claim, it will also include a cancellation or discontinuance of the disability benefit with a retroactive effect, other than for nonpayment of a required contribution. Adverse benefit determinations include but are not limited to the following:

- A payment that results in less than 100% of the billed charges.
- Applying deductible according to Plan provisions.
- Applying co-insurance according to Plan provisions.
- Any non-covered service as outlined in the SPD.
- Nonpayment based on the fact that the claimant is not eligible at the time the charges were incurred.

All Adverse Benefit Determinations are described fully on the Pipeline Industry Benefit Fund Explanation of Benefits Paid (EOB) or Notice of Adverse Benefit Determination which is sent to all participants upon completion of the adjudication process. The explanation or notice will include the following: (i) specific reasons for the determination and Plan provisions on which it is based; (ii) any additional information needed to perfect the claim and why it is needed; (iii) the Claims Appeal Procedure and explanation of the right to file suit under ERISA Section 502(s) if benefits are denied on appeal; (iv) if applicable, an explanation that an internal rule, guideline, protocol or similar criterion was relied upon and that a copy is available upon request free of charge; (v) if the determination is based on medical necessity or experimental treatment or a similar exclusion, a statement that an explanation of the scientific or clinical judgment applying it to your medical circumstances will be provided free of charge upon request; (vi) if it is an urgent care claim, a description of the expedited review process; (vii) information sufficient to identify the claim including the date of service, the health care provider, the claim amount, and a description of the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings; and (viii) for a Disability Claim where proof of disability has not been established, (1) a discussion of the decision including an explanation of the basis for not following the claimant's disability determination and views of the claimant's treating health care professionals and evaluating vocational professionals as presented to PIBF, and a discussion of the views of medical or vocational experts whose advice was obtained for PIBF without regard to reliance; (2) the specific internal rules, guidelines, protocols, standards and criteria relied upon in making the denial or a statement that they do not exist and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim.

Claims Appeal Procedure

If you or a Provider of service should disagree with the decision regarding your claim, you or the Provider may submit a written appeal to the Fund office. Appeals involving urgent care claims or pre-service claims may also be filed by calling the Fund office. This appeal must be submitted within 180 days from the date of receipt of the Adverse Benefit Determination. If a written request for appeal is not made timely, the initial decision on the claim will be final. You may also authorize a representative to file an appeal on your behalf by completing an "Appointment of Authorized Representative Form" available from the Fund office or online at www.pibf.org. If the request for appeal is properly and timely filed, you or the Provider may submit any additional information that supports the appeal. You may also obtain, upon request and free of charge, reasonable access to and copies of all records and information relevant to your claim, as well as the names of any medical or vocational experts whose advice was obtained by PIBF in connection with the initial determination and without regard to whether it was relied upon. The individual involved in the initial benefit denial will not conduct the review of your appeal; nor will a subordinate of that individual conduct the review of your appeal. The review of any claim based on a medical judgment shall be conducted through consultation with a healthcare professional who is independent of any healthcare professional involved in the initial denial decision and who has appropriate training and experience in the field of medicine involved in the medical judgment. The reviewer on appeal will take into account everything relating to the claim that is submitted, without regard to whether it was submitted or considered in the initial determination. No deference will be given to the initial determination. If the appeal involves an urgent care claim, the transmittal of necessary information will be done by telephone, facsimile or other available way to expedite the review.

Before denying a Disability Claim on appeal because of a failure to establish disability, the claimant will be provided, free of charge, with any new or additional evidence or rationale considered, relied upon or generated by PIBF or its reviewer on appeal, as soon as possible and sufficiently in advance to give the claimant a reasonable

opportunity to respond before there is a decision on appeal.

A determination of an appeal will be made by one or more named fiduciaries of the Plan within a reasonable period of time after receipt of the appeal and no later than the following deadlines unless the parties agree to a voluntary extension of time:

- 72 hours for urgent care claims
- 30 days for pre-service claims
- 60 days for all other claims or the date of the meeting of the Board of Trustees that immediately follows receipt of the appeal

unless the appeal is received within 30 days preceding the date of such meeting. In that case, an appeal determination will be made no later than the date of the second meeting following the receipt of the appeal. If circumstances require additional time, an appeal determination will be made not later than the third meeting of the Board of Trustees following the receipt of the appeal. If an extension is required, the Plan will notify the claimant in writing of the extension, describing the circumstances and the date on which the appeal determination will be made. Notice of the appeal determination will be given no later than five days after the determination is made.

If there is an Adverse Benefit Determination on appeal, the notice will give the specific reasons and Plan provisions on which it is based. It will tell you that you are entitled to request, free of charge, access to and copies of all records and information relevant to the claim. If benefits were denied based on medical necessity or experimental treatment or for any other reason, you have the right to request copies of any internal criteria or guidelines that were used in the determination of the adverse decision. This information will be provided to you at no cost upon request. You will be told if any internal rule, guideline or protocol was relied upon and that a copy is available upon request free of charge (or if applicable for a Disability Claim, that they do not exist.)

For a Disability Claim denied on appeal because of failure to establish satisfactory proof of disability, you are also entitled to receive: (1) a discussion of the decision with an explanation of the basis for not following any disability determination or views of treating health care professionals and evaluating vocational professionals submitted by claimant to PIBF; (2) a discussion of the views of medical or vocational experts whose advice was obtained for PIBF regardless of reliance; and (3) a description of the contractual limitations period for bringing a legal action, including the calendar date on which it ends.

Finally, the notice will include a statement of any other available voluntary alternative dispute resolution, and you also have the right to sue for the benefit(s) under §502(a) of ERISA once all appeal procedures have been exhausted with the Pipeline Industry Benefit Fund.

A waiver of time limits may be allowed if the patient is or was mentally or physically incapacitated by an ailment or condition preventing the patient from either notifying PIBF within the allowable time frame or impaired to the extent he/she would not be mentally aware of benefits available.

PPO Discount Disputes

In the event of a discrepancy or dispute in regard to a PPO discount that has been taken on a claim, the provider of service must notify the PIBF office of said dispute within one year from the date the claim was originally paid. If notification is received after this time period, the dispute will be denied, and no adjustment or additional payment will be allowed.

Prior Approval or Pre-Certification Guidelines

The Pipeline Industry Benefit Fund bases coverage determinations on medical necessity. Prior approval in regard to payment or benefit determination is encouraged, but it is not mandatory. The advantage of obtaining pre-approval on the procedure, service, supply or equipment is that there are no surprises or delays in the payment determination. It also affords you or the provider the opportunity to provide all required paperwork that must be on file in the PIBF office prior to the submission of the claim so that there is no delay in payment.

Notification Regarding a Claim (Time Line)

The regulation requires the following time limitations on initial claim approval decisions:

- 72 hours for a decision on urgent care claims
- 15 days for a decision on pre-service claims
- 30 days for a decision on post-service claims
- One 15-day extension for pre-service and post-service claims if needed
- 45 days for a decision on Disability Claims, with one 30-day extension if needed
- 90 days for a decision on death/dismemberment benefit claims, with one 90-day extension if needed

Decisions on appeal of denied claims are also addressed in this DOL regulation. The time frame for the appeal decision on a denied claim is as follows:

- 72 hours for urgent care claims
- 30 days for pre-service claims
- 60 days for all other types of claims or the date of the meeting of the Board of Trustees that immediately follows receipt of the appeal

Claimants have 180 days to file appeals. If the attending physician determines the claim to be "urgent," plans must treat the claim as urgent. On an appeal, the claim must be evaluated by a second source totally independent of the first source of review. The professional medical consultant must be appropriate for the specialty involved in all cases.

Claimants also have the right to request and receive full disclosure regarding the name or names of the medical professionals consulted as part of the claims process. A claim submitted to the PIBF office that has not been approved prior to receiving the service will not be routinely or customarily denied. At the time of processing, additional information may be required if it is not included with the original claim submission. Once the required information is provided to the Fund office, the claim will immediately be re-considered for benefits. Additional information that may be required in order to determine if the claim meets the guidelines for "Medical Necessity" includes but is not limited to:

1. Attending physician's certificate of medical necessity, statement or letter of medical necessity for the procedure, service, supply or equipment ordered.
2. PIBF may require a review by a professional outside source to determine if the procedure, service, supply or equipment ordered qualifies as a medical necessity.
3. Completed claim forms from the member or individual patient.

Pre-Existing Condition

A Pre-Existing Condition is any illness or injury for which medical care was received within the six-month period prior to the covered person's enrollment date. The plan does not exclude coverage of Pre-Existing Conditions for employees and dependents.

Summary of Benefits

DEATH BENEFIT

DISMEMBERMENT & LOSS OF SIGHT BENEFITS

DISABILITY BENEFIT FOR THE ACTIVE EMPLOYEE PARTICIPANT

HEARING AID BENEFIT FOR THE ACTIVE EMPLOYEE PARTICIPANT

PHYSICAL EXAMINATION BENEFIT FOR THE ACTIVE, COBRA, OR RETIRED EMPLOYEE PARTICIPANT

WELDING HOOD LENSES FOR THE ACTIVE & COBRA EMPLOYEE PARTICIPANT

LASER EYE SURGERY FOR THE ACTIVE & COBRA EMPLOYEE PARTICIPANT

COMPREHENSIVE MEDICAL BENEFITS

ANNUAL MEDICAL BENEFITS DEDUCTIBLE

CO-INSURANCE & OUT-OF-POCKET EXPENSE LIMIT

COVERED MEDICAL EXPENSES

As an Employee, you will become covered for the death benefit, dismemberment and loss of sight benefits, disability benefit, and the other benefits described in this Section when you satisfy the eligibility requirements and become covered under the Plan. Coverage for these benefits will continue until coverage ends due to insufficient hours/termination.

*Death Benefit - $20,000 for the Active Employee Participant**

The death benefit is $20,000 and is self-insured by PIBF. A written claim for death benefits must be made with the PIBF office. Death claims filed more than 1-year after the date of death may require Trustee approval. It will be paid within 90 days of death while covered by the Plan, directly to the Beneficiary designated on your PIBF Census Data Form, if surviving. Your Beneficiary must provide proper proof of your death before obtaining the death benefit. If no valid Beneficiary has been designated or survives you, the Beneficiary will be deemed to be the Employee's Surviving Spouse, or if none, the Employee's Surviving child(ren); or if none, the Employee's surviving parent(s); or if none, the Employee's surviving sibling(s); or if none, the Employee's estate. If a former spouse was designated the beneficiary before a divorce or legal separation, the designation will be deemed nullified by the divorce or legal separation.

You may change your Beneficiary at any time by giving written notice to the PIBF office. In the event of a divorce, a new PIBF Census Data Form must be submitted to the PIBF office. A Beneficiary change will become effective when it is entered into PIBF records prior to payment of the death benefit.

If it is the opinion of the Trustees that your designated Beneficiary is physically, mentally, or legally incapable of accepting the death benefit, the Trustees have discretionary authority to authorize payment to a person or persons legally appointed to accept the settlement on behalf of the designated beneficiary.

*The $20,000 death benefit is as of April 1, 2018. Prior to that date, the death benefit was $10,000 and an additional $10,000 was available for accidental death claims.

Dismemberment & Loss of Sight Benefits - $10,000 for the Active Employee Participant

$10,000 Dismemberment Benefit

For dismemberment or for loss of sight occurring within 24 months** of an accidental bodily injury, and resulting solely from such injury, you will be paid $10,000 if you suffer any of the following losses:

- Dismemberment of both hands
- Dismemberment of both feet
- Loss of sight in both eyes
- Dismemberment of one hand and one foot
- Dismemberment of one hand and loss of sight in one eye
- Dismemberment of one foot and loss of sight in one eye

The dismemberment benefit covers any of the above losses resulting from any injury from any accident which occurs while you are covered for this benefit.

$5,000 Dismemberment Benefit

If you sustain any of the following losses within 24 months** of an accidental bodily injury which occurs while you are covered and resulting solely from such injury, PIBF will pay you a $5,000 benefit:

- Loss of one hand
- Loss of one foot
- Loss of sight in one eye

Dismemberment means complete severance through, or above, the wrist or ankle joints.

Loss of sight means entire and irrecoverable loss of sight, including light perception.

Note: The death and dismemberment benefits are payable in addition to any other PIBF benefits. However, when multiple losses occur, only one death or dismemberment benefit (the larger) is payable under the death and dismemberment benefit.

The dismemberment benefit does not cover losses resulting from suicide or attempted suicide or losses in which a felony or an illegal occupation was a contributory cause.

** Formerly "within 90 days." This was modified in September 2017.

Disability Benefit for the Active Employee Participant

- $250 per week for a maximum of 26 weeks
- Payments begin the 1st day of accident or 8th day of illness.

The disability benefit is payable as described in this Section only if you become Totally Disabled as a

result of an accident or illness which occurs while covered by the Plan. To receive benefits, written notice of Total Disability must be submitted to PIBF within 180** days of the first day of disability. Continuation of benefits is not automatic. As a minimum, you must submit bi-weekly disability forms, which your Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) has completed.

You are "Totally Disabled" when you are unable to perform any type of work because of injury or illness. If you qualify, you may receive a weekly $250 disability benefit, subject to the following provisions, for a maximum period of 26 weeks per disability:

- Payments will begin on the 1st day of a disability due to an accident and on the 8th day of a disability due to an illness, but no payments will be made for any day of disability prior to the first medical treatment you receive for the disability. A Doctor of Medicine or Doctor of Osteopathy must provide medical treatment.

- To be eligible for payments, the Total Disability from an injury must occur, and treatment must be received, within 10 days after the date of the accident.

- If you are disabled twice by the same cause and these periods of disability are separated by more than 30 days of Covered Employment, you will be eligible for a maximum of 26 weeks of disability benefits for each period.

- If you are disabled twice by unrelated causes and the periods of disability are separated by at least one day of Covered Employment, you will be eligible for a maximum of 26 weeks of disability for each cause.

- You cannot receive disability benefits for a disability resulting from:
  - An act of war.
  - An injury in which a felony or an illegal act is a contributory cause.
  - Alcohol or drug abuse.

- You cannot receive disability benefits if you are retired under the PIPF.

- You cannot receive disability benefits if you are covered under the PIBF COBRA program.

** Formerly "within 90 days." This was modified in September 2017.

Hearing Aid Benefit for the Active Employee Participant

The PIBF hearing aid benefit was approved January 1, 1990. This benefit is available to working members with eligibility under the Active plan. It is not available to COBRA or Retiree plan participants and is not available to Dependents. PIBF will pay Reasonable Expenses Incurred up to $1,000, every five calendar years, toward the cost of the hearing aid(s). This benefit is a special stand-alone benefit and is not subject to the calendar year deductible.

Physical Examination Benefit for the Active, COBRA, Or Retired Employee Participant

This benefit is available to all members who qualify for medical coverage but not to covered Dependents. PIBF will pay Reasonable Expenses incurred for a physical examination by a licensed medical provider. This benefit pays 100% of the first $200.00 and is available every calendar year. Excess charges will be considered under the PIBF Medical benefits plan and subject to the deductible and/or co-insurance.

Welding Hood Lenses for the Active & COBRA Employee Participant

Every covered Employee with active or COBRA coverage qualifies for a $75.00 annual vision care benefit, which can be used for Reasonable Expenses Incurred for the cost of obtaining a prescription insert lens for a welding hood.

This is only one segment of PIBF's vision care plan. The major portion is described in detail within this presentation in the section titled, "Vision Care."

Laser Eye Surgery for the Active & COBRA Employee Participant

The PIBF laser eye surgery or Lasik benefit is available to working members with active or COBRA medical coverage. It is not available under the Retirees coverage and is not available to Dependents. PIBF will pay up to $1,000 on a one time only basis for Reasonable Expenses Incurred for laser eye surgery (including any related exam or evaluation charges). Benefits for this procedure are provided in lieu of any other routine eye care benefits under the PIBF vision benefits for the calendar year in which the service is rendered.

This benefit is a special stand-alone benefit and is not subject to the calendar year deductible or co-insurance.

Comprehensive Medical Benefits

Comprehensive medical benefits are payable for expenses incurred by covered Employees and Dependents for medical care, services, and supplies covered by the Plan as described in this Section, subject to Plan limits. These benefits are self-insured by PIBF. An expense is incurred on the date the service or supply for which it is charged is furnished.

*Annual Medical Benefits Deductible**

- Individual Deductible = $500 per person, per calendar year
- Family Maximum Deductible = $1,000 per family, per calendar year ($500 is the maximum amount a covered individual family member can count toward meeting the family deductible).

*The amount a covered individual (or covered family members) must incur and pay out-of-pocket for covered medical services/supplies during a calendar year before comprehensive medical benefits are payable to him (or the family members) for covered expenses incurred during the remainder of the calendar year.

Annual Medical Benefits Deductible for Retirees and Dependents with Medicare

As of January 1, 2008, only covered expenses incurred for in-patient care (the portion of your charges considered under Part A of Medicare) will be subject to the annual deductible for Retirees and their Dependents entitled to Medicare.

There will be no annual deductible on charges incurred for office service, or other out-patient services for covered Retirees and their Dependents with Medicare (the portion of your charges considered under Part B of Medicare).

Annual Pharmacy Benefits Deductible*

- Active and COBRA Coverage for Employees & Dependents
  $100 per person per calendar year or $200 per family per calendar year ($100 is the maximum amount a covered individual family member can count toward meeting the family deductible).
- Retiree Coverage for Retirees and Dependents
  $250 per person per calendar year or $500 per family per calendar year ($250 is the maximum amount a covered individual family member can count toward meeting the family deductible).

*The amount a covered individual or family member must incur and pay out-of-pocket for covered pharmacy expenses during a calendar year before pharmacy benefits are payable for his (or the family's) covered pharmacy expenses incurred during the remainder of the calendar year.

Annual Dental Benefits Deductible for Active and COBRA Coverage (Employees & Dependents)

(Retiree coverage does not provide Dental coverage.)

- $100 per person, per calendar year

*The amount of expenses a covered individual must incur and pay out-of-pocket for covered dental services/supplies before dental benefits are payable for dental expenses incurred during the remainder of the calendar year.

Co-Insurance and Out-of-Pocket Expense Limit

Co-Insurance means the percentage of covered expenses incurred by a covered individual during a calendar year that is payable by the Plan after satisfaction of the annual deductible (subject to Plan limits and exclusions).

PIBF may contract from time to time with a Preferred Provider Organization (PPO) to offer covered individuals discounted rates for participating hospitals, physicians, and other medical providers. PIBF currently participates in the BCBS Medical PPO Network.

Co-Insurance Percentage Payable by Plan for In-Network/PPO Providers – benefits paid at 80% of PPO contracted rate after yearly deductible has been satisfied.

Co-Insurance Percentage Payable by Plan for Out-of-Network/non-PPO Providers – benefits paid at 70% of Reasonable Expenses Incurred after yearly deductible has been satisfied.

The In-Network and Out-of-Network percentages will not apply whenever the Plan coverage is secondary to another carrier (including Medicare for a retiree).

The Plan also has an individual Out-of-Pocket (OOP) limit that affects the co-payment percentage. The OOP is:

- In Network = $5,000
- Out of Network = $7,500

OOP is the amount of co-insurance you are responsible for on covered medical charges incurred during a calendar year (i.e., 20% for In-Network and 30% for Out-of-Network) before all eligible charges incurred by you in that calendar year will be paid at 100% up to the Plan limits of coverage. OOP does not apply to non-covered services/supplies or the excess on stand-alone benefits.

Pre-Admission Certification
All non-emergency inpatient admissions (other than for childbirth) when the Plan is the primary carrier, must be pre-certified prior to admission. Unless Medically Necessary, hospital and related physician charges for weekend hospital admissions (Friday, Saturday & Sunday) for non-emergency procedures will not be covered. All emergency admissions must be certified no later than 48 hours following admission.

Covered Medical Expenses

Once you and your Dependents have established eligibility with the Pipeline Industry Benefit Fund and become covered, you and your eligible Dependents will qualify for benefits until coverage terminates. The individual or family maximum deductible must be met each calendar year before PIBF comprehensive medical benefits are payable.

Following is a list of the most commonly covered medical expenses. If you are ever in doubt as to whether or not a specific service or procedure is covered by the Plan, you should call the PIBF office for assistance. This list should not be considered complete in regard to all covered medical services. The Plan provides comprehensive medical coverage for the medical care, services and supplies described below, when Medically Necessary as determined by the Plan, based on recommendations by a Medical Doctor or Doctor of Osteopathy and in accordance to guidelines of appropriate care as indicated by the American Medical Association, unless it is a wellness benefit specifically covered. In some instances, PIBF may request additional information from you or the attending physician documenting the medical necessity of services. In order to be covered, the expenses must be incurred while you or your Dependent is covered by the Plan. Coverage is based on the contracted rates when a PPO provider is used, or the Reasonable Expenses incurred when a non-PPO provider is used.

- Hospital Room & Board (not to exceed rate for semi-private room unless Medically Necessary)
- Hospital Miscellaneous Expense
- Skilled Care, Long Term Acute Care or In-patient medical rehab limited to 100 days per calendar year
- Hospital Visits by Physicians
- Surgical Benefits
- Organ Transplant(s)
- Office Visits, Injections
- Out Patient Hospital Service
- Emergency Room Service
- X-Ray and Laboratory Expense
- Sleep Study
- Durable Medical Equipment when deemed Medically Necessary and prescribed or ordered under the supervision of a medical doctor (M.D.) or doctor of osteopathic medicine (D.O.)
- Dental care treatment to repair or alleviate damage caused solely by an accident
- Hospice Care
- Cardiac Rehabilitation (following a cardiac procedure)
- Speech Therapy when deemed Medically Necessary and considered restorative or rehabilitative. Speech Therapy due to developmental delay will be subject to a twenty visit per year limit.
- Post-surgical Physical Therapy, Post-hospitalization Physical Therapy, and Physical Therapy deemed medically necessary due to an extended illness
- Maternity Benefits for Employee and Dependent Spouse only
- Ambulatory Surgical Facility
- Ambulance Service when needed for transport to a hospital for medical emergency
- Cat Scan, MRI, MRA or another medically necessary diagnostic imaging service
- Dialysis
- Reconstructive breast surgery in accordance with the Women's Health & Cancer Rights Act
- Plastic or cosmetic surgery to repair or alleviate damage caused solely by an accidental bodily injury
- Behavioral Health
- Substance Use Disorder Treatment (Effective January 1, 2026)
- Weight loss medication and some weight loss surgical procedures can be covered when certain criteria are met. Weight loss medication criteria include Plan established guidelines for diagnosis of Morbid Obesity - Body Mass Index of 35 or higher with co-morbidities (serious medical conditions) such as pre-diabetes, diabetes, high blood pressure, sleep apnea,

lower extremity joint pain, shortness of breath, participation in a physician-supervised diet program; psychological evaluation and other guidelines established by the Plan. Weight loss surgical procedure criteria include Plan established guidelines for diagnosis of Morbid Obesity - Body Mass Index of 40 or higher with co-morbidities (serious medical conditions) such as pre-diabetes, diabetes, high blood pressure, sleep apnea, lower extremity joint pain, shortness of breath; participation in a physician-supervised diet program, psychological evaluation and other guidelines established by the plan. Weight loss medications require prior authorization by the Sav-Rx clinical department and may be subject to step therapy.

- Wellness & Preventative Benefits including yearly screening exams for pap, mammogram or PSA
- Routine Immunizations recommended and endorsed by the U.S. Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). PIBF follows the age guidelines established by the medical profession. Currently, PIBF covers immunizations or vaccines for all routine childhood diseases as well as Influenza, Pneumonia, Hepatitis A & B, Human Papillomavirus, Shingles, Meningitis, and COVID-19.
- Immunizations for international travel recommended and endorsed by the CDC.

Benefit Substitution

Benefit Substitution to covered individuals on a one-time only basis to provide the oppurtunity to choose an alternative medical procedure that may not be covered in place of a covered procedure. Substitutions cannot exceed Plan limits or the amount of benefits that would have been payable for the covered procedure and must be documented by the medical provider to establish a basis for substitution and establish cost comparison. If the cost of this Benefit Substitution is less than that of the covered procedure and the participant then needs to have the covered procedure, coverage under the Plan will be limited to the difference in cost. This provision will also be referred to as "cost-shifting." Please contact the PIBF office if you would like additional information on Benefit Substitution.

Description of Stand-Alone Medical Benefits for all PIBF Participants & Dependents

STAND-ALONE MEDICAL BENEFITS

CHIROPRACTIC BENEFITS

PHYSICAL THERAPY BENEFITS

STERILIZATION BENEFITS

Stand-Alone Medical Benefits

The following benefits are not subject to the calendar year deductible or co-insurance and are payable for expenses incurred by a covered individual while covered by the Plan. The excess or non-covered portion is not covered under comprehensive medical benefits and does not apply to the patient's deductible or out-of-pocket limit.

Chiropractic Benefits

- PIBF pays $50* per visit, up to a maximum of $1,000 per person, per calendar year.

  *The $50 per visit and $1,000 maximum benefit is as of January 1, 2026. Prior to that date, the benefit was $25 per visit and $500 maximum.

Physical Therapy Benefits - Non-Surgical Physical Therapy, Biofeedback or Pulmonary Rehab

- This benefit pays a maximum of $100* per visit for nonsurgical physical therapy, biofeedback or pulmonary rehab when recommended by an M.D. or D.O.

  * The $100 per visit benefit is as of January 1, 2026. Prior to that date, the benefit was $50 per visit.

Sterilization Benefits - Available for the Member or Dependent Spouse Only

- PIBF will pay a maximum of $1,000* for all expense related to a Vasectomy.

  *The $1,000 maximum benefit is as of January 1, 2026. Prior to that date, the maximum benefit was $500.

Description of Benefits for PIBF Participants & Dependents

PRESCRIPTION BENEFITS

Prescription Benefits

Expenses incurred for prescription drugs, while covered by the Plan, are covered to the extent described in this Section. The Plan may contract with a discount prescription provider and/or prescription drug benefits administrator to offer a network of participating pharmacies to you and your Dependents and/or to administer the prescription benefits provided by the Plan. The Plan has currently contracted with Sav-Rx Prescription Services to manage its Prescription Drug Program (effective January 1, 2022).

A list of the participating pharmacies will be available to you, without charge, separately from this booklet. The name of the nearest participating pharmacy can be obtained by calling Sav-Rx Customer Service, toll-free: 1-800-228-3108.

OR

To locate the nearest pharmacy online, please visit www.savrx.com.

Prescription Benefit Card

All participants should receive a Prescription Benefit Card. You will need to present your Prescription Benefit Card to the pharmacist to have your prescriptions filled at a participating pharmacy.

The Pipeline Industry Benefit Fund Sav-Rx drug card does not indicate an expiration date. Therefore, the same card can be used for later coverage if, for example, a participant loses eligibility and later re-establishes eligibility, or is covered due to retirement, or COBRA.

If you have not received your Prescription Benefit Card, contact PIBF for assistance or visit the member portal at www.pibf.org to request your card.

Prescription Benefit Deductible and Co-Pay

In order for a prescription medication to be covered, the medication must be:

- Prescribed by a licensed physician; and
- A prescription medication approved by the Food and Drug Administration (FDA).

The Prescription Drug Benefits plan deductible and co-pays do not count toward the out-of-pocket limit on the Medical Benefits.

Prescription Drug Benefit Deductible

- Active & COBRA Coverage: $100 deductible per person or $200 maximum per family per calendar year.

- Retiree Benefits: $250 deductible per person or maximum $500 per family per calendar year.

Prescription Drug Benefit Co-Pay

- Minimum of $5.00 or 30% payable by participant when covered prescription medication is purchased at the pharmacy counter. The co-pays apply to “A” rated generic equivalent.

- Minimum of $5.00 or 20% payable by participant when covered prescription medication is purchased through the mail service.

The patient will be responsible for the difference in cost and applicable copay when a brand-name medication is requested in a place of an FDA "A"-rated generic equivalent. An exception may be granted if the prescribing physician submits a Letter of Medical Necessity to the Sav-Rx Clinical Department, outlining why the specific brand-name product is required. The Sav-Rx Clinical Department will review the submitted information and determine approval or denial based on clinical considerations and contraindications to the preferred product.

Co-Pay – Double Covered Participants

All covered family members, when the Employee and Dependent spouse are both covered as Employees, will be allowed to submit their paid prescription drug co-pay receipt(s) to the Fund office for reimbursement at 100% during the calendar year once their deductible for the calendar year has been met.

Retired Participants with Medicare

Retiree health coverage includes retiree prescription coverage unless the plan participant opts out of the prescription coverage. Retirees with health coverage can opt out of the prescription program and return on a one-time basis provided the retiree had drug coverage elsewhere. The PIBF prescription plan is a Part D Medicare plan equivalent.

Filing for Reimbursement

If you have a prescription filled by an out-of-network pharmacy, you will be required to pay the full amount of the prescription at the time of purchase and file for reimbursement separately.

To be reimbursed for covered medications purchased from a non-participating pharmacy, you must file a claim with Sav-Rx. To request a reimbursement form, call 1-800-228-3108 or the PIBF office.

Complete the form and mail to:

Sav-Rx Presciption Services
224 North Park Ave.
Fremont, NE 68025

Note: You may have to pay more for your prescription(s) if you use an out-of-network pharmacy.

Difficulty Having a Prescription Filled?

Ask the Pharmacist to call Sav-Rx at the number listed on the back of your Prescription Benefit Card. If you need further assistance, contact the PIBF office at 918-280-4800.

Mail Service

The Mail Service portion of your Prescription Drug Benefits Program is administered by Sav-Rx Prescription Services. This program is designed primarily for individuals taking maintenance medications used to treat chronic or long-term conditions such as diabetes, arthritis, heart conditions, and high blood pressure. The Sav-Rx home delivery service allows participants to receive up to 90-day supply of medication delivered to their home.

Sav-Rx Prescription Services Mail Service Pharmacy is commtted to maintaining the highest standards of quality, safety, and effectiveness. Your prescription history is maintained to help identify potential drug interactions or adverse reactions with medications filled through Sav-Rx Mail Service Pharmacy or any participating Sav-Rx Network Pharmacy. If any concerns arise regarding possible drug interactions or other medication-related issues, a pharmacist will contact you or your physician before dispensing the medication.

Benefits

- Cost-effective and convenient solution for long-term maintenance and specialty medications
- Free shipping delivered directly to your door
- Up to a 90-day supply of medication per order
- Easy refill options by phone, online, or through the Sav-Rx Patient Portal

How it Works

1. Send in your prescription
2. Pay at the time of order
3. Receive your medication delivered directly to your door
4. Enjoy easy refills by phone, online, or through the Sav-Rx Patient Portal

How to Send Prescriptions - 3 Options

1. **Electronic Prescribing (Preferred Method)**
   Ask your doctor to send your prescription electronically to Sav-Rx in Fremont, Nebraska.

2. **Fax**
   Ask your doctor to fax your prescription to:
   (402) 753-2890

3. **Phone**
   Call Sav-Rx with your prescription details and your doctors information. Sav-Rx will coordinate directly with your provider. Call: 1-800-228-3108

Sav-Rx Patient Portal

Use the Sav-Rx Patient Portal to:

- Access your electronic ID card
- Compare medication costs using the drug price lookup tool
- Download your entire prescription claim history
- Maintain your profile and payment method
- Order medications from the mail order pharmacy
- Track your current order status
- Receive notifications when mail order refills are due
- View your mail order prescriptions

Visit:
Sav-Rx Online Services at:
www.savrx.com

Please have the following information available when ordering refills:

- Participant ID number
- Prescription number(s)
- Credit Card Information (if applicable)

Generic Equivalents

The generic version of a drug has the same chemical compound as its brand name counterpart. The use of generic drugs offers a simple and safe alternative to help reduce prescription drug costs for you and PIBF.

Medications Not Covered by The Prescription Drug Benefits

- Over-the-counter medications including vitamins and supplements
- Investigational or experimental drugs
- Fertility/infertility drugs
- Medications for cosmetic purposes
- Weight loss medications that do not meet the criteria otherwise outlined in the Plan
- Drugs not approved by the FDA
- Drugs not approved for sale in the United States
- Drug dosages that exceed FDA approval
- Drugs approved by the FDA but used for conditions other than those indicated by the manufacturer.

Call Sav-Rx Customer Service at 1- 800-228-3108 if you:

- Have questions about your prescription drugs and would like to speak to a pharmacist.
- Would like to request additional Prescription Benefit Cards.
- Would like to know if your pharmacy is a participating provider.

Visit Sav-Rx Online at www.savrx.com

Description of Benefits for PIBF Participants & Dependents

DENTAL CARE BENEFITS

Dental Care Benefits

PIBF may contract with a Preferred Provider Organization (PPO) to offer covered individuals discounted rates for participating dental providers. PIBF currently participates in a dental network, and the co-insurance payable for Dental Care Benefits varies depending on whether you use a dental provider within the PPO Network. A list of the dental providers participating in the PPO Network will be available to you without charge, separately from this booklet.

Pre-certification of dental services to be rendered is not required. X-rays do not need to accompany submitted claims unless the services are for crowns on the upper and/or lower front teeth.

- $1,000.00 maximum Dental Care Benefits per person each calendar year
- Payment will be made according to the Dental Care Benefits which is described in this Section
- $100.00 Dental deductible per person per calendar year except as otherwise noted
- Children under the age of 19 will be covered for dental check-ups to the extent required under the Affordable Care Act

Dental Care Benefits – NOT Subject to Yearly Dental Deductible or $1,000 annual maximum Paid at 100% of Reasonable Expenses

- Routine Exam: every 6 months
- Prophylaxis: every 6 months

The remaining stated dental care will be paid at 80% of Contracted Rate In-Network and 70% of Reasonable Expense Out of Network

Dental Care Benefits – Subject to Yearly Dental Deductible

- Bitewing x-rays
- Fluoride
- Full mouth x-rays
- Panoramic x-rays
- Sealant, per tooth
- Problem-Focused Exams
- PA X-rays

Extractions

Fillings

(Except Sedative fillings are Not Covered)

Palliative

Emergency visit for relief of pain (excluding prosthetic adjustment or periodontia treatment)

Periodontia

- Actisite therapy, per quadrant
- Gingivectomy/Root planning, per quadrant
- Osseous surgery, per quadrant
- Tissue grafts, per quadrant
- Bone grafts, per site
- Bacteriological exam
- Occlusal guard/Bruxism

Oral Surgery

- Apicoectomy, per root
- Alveolectomy
- Cyst removal including extraction
- Tori removal
- Incision and drainage
- Removing labial frenum
- Endodontics
- Pulp Caps
- Pulpotomy
- Root Canals

Dental Anesthesia

Space Maintainers

Denture Repairs

- Repair body of broken denture
- Replace broken teeth in denture per tooth
- Replace broken clasp
- Replace broken facing

Dentures & Partials

- Full dentures (upper & lower)
- Partials (upper & lower)
- Rebasing
- Relining (Office Acrylic or Laboratory)
- Adding teeth to partial

Crown

- Inlay used as abutment, 1 surface
- Inlay, 2 surfaces
- Inlay, 3 surfaces
- Maryland Bridge
- Full cast
- ¾ crown
- Pontics

- Removable bridgework
- Acrylic jacket
- Porcelain jacket
- Shell crowns
- Crown build-up/Post & Core
- Pin retention
- Re-cementing inlays or crowns

Services NOT Covered Under the Dental Care Benefits:

- Orthodontic Services
- Treatment for TMJ
- Dental Implants

(See “General Plan Exclusions” for complete list)

Description of Benefits for PIBF Participants & Dependents

VISION CARE BENEFITS

Vision Care Benefits

Vision Care Benefit available only to Active and COBRA Participants and their covered Dependents except as otherwise noted (not available to Retirees and their Dependents).

PIBF will pay up to a maximum of $200.00 in Vision Care Benefits per person every calendar year for covered expenses incurred while covered under the Plan for normal vision care services. The PIBF Vision Care Benefit is not available when service is provided for an illness condition or accident (vision services provided for an illness or accidental injury would be covered, if at all, under Medical Benefits and not Vision Care Benefits). Typical vision care services and materials, which will qualify for reimbursement through this benefit, are:

- Vision screening
- Vision analysis
- Prescription lenses
- Frames
- Necessary servicing of frames and lenses
- Prescription contact lenses
- Children under the age of 19 will be covered for an annual routine eye exam and materials to the extent required under the Affordable Care Act

Lasik Eye Surgery

The Lasik benefit described in this Section is available only to working members with eligibility as an active Employee or under COBRA. It is not available to Dependents or Retirees. PIBF will pay up to $1,000 on a one-time-only basis for covered expenses incurred for Lasik eye surgery (including any related exam or evaluation charges). Benefits payable for this procedure are provided in lieu of any other routine Vision Care Benefits otherwise payable for the individual for the calendar year in which the Lasik eye surgery or related services are rendered. This benefit is a special stand-alone benefit and is not subject to any deductible.

Welding Hood Lenses

PIBF will pay up to $75.00 per calendar year for covered expenses incurred by an Employee with active or COBRA coverage for the cost of obtaining a prescription lens insert for welding hoods. Dependents and Retirees are not eligible for this special benefit.

Cataract procedures are covered under the Health and Welfare Plan

Description of Benefits for PIBF Participants & Dependents

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) BENEFIT

Health Reimbursement Arrangement (HRA) Benefit

Summary of HRA benefits for Active, COBRA, and Retiree Participants

On January 1, 2008, the Board of Trustees of the Pipeline Industry Benefit Fund established the Health Reimbursement Arrangement, also referred to as the HRA. The HRA benefit is available to Employees with active, COBRA and retiree coverage who are eligible and are receiving health benefits under the Pipeline Industry Benefit Fund Health & Welfare Plan. The HRA benefit is also available to a Dependent who elects individual COBRA coverage.

An individual's participation in the HRA will continue until the earlier of the date on which his coverage under the Plan ends or the date the HRA is terminated.

The HRA is a health care reimbursement account, funded by the Employer, which allows the covered Employee or Retiree to obtain reimbursement of eligible Medical Care Expenses for himself and eligible Dependents. It is intended to qualify as a medical reimbursement plan under Code Sections 105 and 106 and the corresponding regulations, and as a health reimbursement arrangement as defined in IRS Notice 2002-45. The Medical Care Expenses reimbursed under the HRA are intended to be eligible for exclusion from your gross income under Code Section 105(b). The HRA plan requires Trustee approval each calendar year. The amount of the funds from the reserves that will be credited to the HRA accounts for each calendar year, if any, will be established by the Board of Trustees prior to the beginning of the calendar year. The HRA plan may be revised, amended or terminated at any time at the sole discretion of the Trustees of the PIBF.

The HRA account will be established for each covered Employee or Retiree, solely for record-keeping purposes, in order to keep track of funding and available reimbursement amounts. The Plan will not create a separate fund or segregate assets in connection with the HRA accounts. No one has a vested interest in an HRA account. There is no carry forward or roll-over of any balance remaining in the HRA to the following year.

Should a working member lose active coverage during the calendar year , and he chooses to continue his coverage under the COBRA plan, the remaining HRA balance will continue to be available to him for reimbursement under the HRA plan.

A retired widow will also be eligible to receive the HRA benefit, subject to the same rules as the retired member.

The HRA balance will be suspended during any month or months that the member loses eligibility and does not continue coverage under COBRA. Once eligibility is re-established, any remaining HRA balance will once again be available.

April 15th* is the filing deadline for HRA claims for the previous year's Medical Care Expenses.

**Effective January 1, 2019 – Previously March 31st*

In order to obtain reimbursement from your HRA, you must timely submit to the PIBF office a completed HRA claim form and adequate supporting documentation (e.g., a bill, invoice, Explanation of Benefits or other statement from an independent third party showing that the Medical Care Expense has been incurred and the amount). HRA claim forms are available at the PIBF office. Instructions for filing are printed on the back of the HRA form. You can also log onto the PIBF Web site at www.pibf.org and click on the appropriate link to access and print a form. Any balance remaining in your HRA after all timely filed claims have been processed and paid will be forfeited.

Your HRA account is intended to provide reimbursement solely for eligible Medical Care Expenses, as defined in this Section, that have not previously been reimbursed and are not reimbursable elsewhere. Reimbursement under the HRA benefit cannot be made until the claim has been processed and payment determined by any and all other available health plans or coverage. For example, if there is medical benefits coverage available under the PIBF Health & Welfare plan, Medicare or any health insurance policy through you or a spouse's employment, you must provide a copy of the explanation of benefits statement (or EOB) showing the amount covered and the remaining balance after all other health plans or coverage have paid.

You may use your HRA account solely for obtaining reimbursement of eligible Medical Care Expenses as described below, incurred by you or your covered Dependents while covered by the HRA, up to the unused amount. Medical Care Expenses are expenses incurred for medical care, as defined in Code Section 213. These include amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body. The following expenses are examples of expenses eligible for

reimbursement under the HRA:

- Medical expenses applied to satisfy the Medical Plan Deductible
- Prescription expenses applied to satisfy the Prescription Drug Benefit Deductible
- Vision care expenses incurred by Retirees
- Dental expenses incurred by Retirees
- Hearing Aid Expense
- Medical or Dental expenses attributable to the Co-insurance payable by the individual
- Dental expenses applied to satisfy the yearly Dental Deductible
- Vision Expense in Excess of Vision Benefit Limits
- Prescription drug expenses attributable to the Co-Insurance payable by the individual
- Prescription Smoking Cessation Medicine or other medications not covered by Prescription Drug Benefits
- Lasik for Vision Correction expenses in excess Of Vision Benefits coverage or for a Retiree or other person without coverage

Over the counter medications (OTC medications) and cosmetic procedures including prescriptions related to cosmetic procedures, expenses for long-term care services and amounts paid for any employee or group insurance coverage, including COBRA and extended coverage self-payment amounts are not eligible for reimbursement under the HRA. If a dispute arises over coverage for a specific item, it will be subject to claims procedures and a determination of coverage that will be made based on terms of the Plan.

Reimbursement under the HRA plan is made to the covered Employee, Retiree, or retired widow only. This benefit cannot be assigned to any other person or medical provider. Documentation you send with the HRA claim form will not be returned; therefore, you may want to make a copy to keep for your records. If your claim for reimbursement is denied, you may appeal the denial and receive a full and fair review in accordance with the Plan's claims review procedures. According to the IRS, medical expense reimbursed through a Health Reimbursement Arrangement cannot be claimed as a medical expense deduction on your taxes.

The Plan makes no guarantee that any reimbursement made to you under the HRA will be excludable from your gross income for federal, state or local income tax purposes. It is your obligation to determine if payments under the HRA are excludable from your gross income and to notify PIBF if you have any reason to believe that a payment is not excludable. If you receive reimbursement on a tax-free basis and it does not qualify for tax-free treatment, you will be required to indemnify and reimburse PIBF for any liability it may incur for failure to withhold taxes from the payment. In the event of a mistake regarding your participation, allocations to or reimbursements from your HRA account, the Plan reserves the right to make such adjustments as it deems proper to correct the mistake, to the extent administratively possible and legally permissible.

There are nondiscrimination requirements under Code Section 105(h) that affect reimbursements under HRA accounts to participants who qualify as "highly compensated" Employees. These requirements are not expected to impact this Plan, but if they do, reimbursements to any such Employees may be limited or treated as taxable compensation as the Plan deems necessary to comply with the nondiscrimination requirements.

Filing an HRA Claim:

1. **Complete Top Portion of Form**
   - Employee name
   - PIBF U.I.D. #
   - Patient name (one family member per form)
2. **List Healthcare Expenses**
   - Service Date
   - Provider name/Pharmacy name
   - PIBF claim number
   - Member Balance (This is your out of pocket expense)
   - Itemized pharmacy statement instead of individual RX receipts
3. **Sign, Date and Submit the Form**

******** **Fact** *********

- ❖ It is not necessary to send copies of EOB's if you provide the claim number under claim number/expense description column.
- ❖ Waiting to file at the end of the year delays processing time. File HRA as charges are incurred throughout the year.
- ❖ HRA claim status <u>cannot</u> be given over the phone. Visit the member's section of our website to inquire about the status of your HRA claim.

(Allow 4-6 weeks for processing)

General Eligibility

PARTICIPANTS ELIGIBILITY

DISABILITY PROVISION - POSTING OF HOURS

DEPENDENTS ELIGIBILITY

ELIGIBILITY FOR RETIRED PARTICIPANTS & PERMANENTLY & TOTALLY DISABLED PARTICIPANTS

COVERAGE FOR RETIRED PARTICIPANTS & THEIR DEPENDENTS

COVERAGE CONTINUATION UNDER COBRA

COORDINATION & NON-DUPLICATION OF BENEFITS

RIGHT OF REIMBURSEMENT & SUBROGATION

Participants Eligibility

If both member and spouse are eligible under the PIBF Plan as members, each will be covered under the Plan both as a member and as a Dependent of their respective spouse; and children who qualify as Dependents may be covered as Dependents of both the member and spouse, subject to coordination of benefits provisions.

Qualifying for Eligibility (Effective February 1, 2023) – Initial Eligibility for Journeymen

If you are an Employee working as a Journeymen, you must work 800 hours in Covered Employment during 12 or fewer consecutive months to satisfy the initial eligibility requirements, become a PIBF participant and qualify for benefits.

Your initial eligibility for benefits will begin on the first day of the month in which you complete the 800th hour of Covered Employment for which the Employer is obligated to make PIBF contributions and continue for 6 months. Your coverage will then continue on a month-to-month basis to the extent described in the following section. Plan participants obtaining eligibility as a result of coverage under a Participation Agreement or any other similar document will follow the eligibility requirements of that document; otherwise, the rules of the plan will prevail.

Extending Your Eligibility (Journeymen)

Your coverage is automatically extended as you continue to do the minimum amount of Covered Employment required to maintain eligibility. Every 120 hours of Covered Employment provides one (1) month of coverage. In other words, once the initial eligibility requirements have been met, you always have benefit coverage extending for a month if you have at least 120 hours of Covered Employment during the current month and preceding months.

Once you satisfy the initial eligibility requirement, you can accumulate up to 1,440 excess hours in Covered Employment in an hour bank maintained on your behalf to provide for future months of coverage.

Reinstatement of Eligibility (Journeymen) (Effective August 1, 2002)

If your eligibility for benefits terminates, and you have a 12-month gap in Covered Employment, any hours you have remaining in your hour bank will be forfeited, and you must work at least 500 hours of Covered Employment within 12 or fewer consecutive months to re-establish coverage. Once you have a 60-month gap in coverage, you must work at least 800 hours of Covered Employment within 12 or fewer consecutive months to re-establish coverage, which is the same as the initial eligibility rules of the Plan. Hours remain in the participant's hour bank as long as hours are being contributed to the Fund without incurring a 12-month gap in Covered Employment. The provision for COBRA participants allowing the extension of the time period up to twelve months has been eliminated. Effective February 1, 2018, the extension of eligibility is based entirely on hours worked.

Here is an example which will help you understand the extension policy:

Example:
You have 800 hours of credited Covered Employment, which you have performed during the period of January 1 through June 30. You earned the 800th hour of work on June 30. Consequently, you became eligible for 6 months of benefits (800 hours divided by 120 hours equals 6 months of coverage with 80 hours remaining) beginning on June 1 since your coverage becomes effective on the first day of the month in which you perform the 800th hour of work.

For every 120 hours you work in Covered Employment during the following months, your eligibility will be extended one month. Unused hours will be carried forward and added to future hours worked.

Now, suppose that after working the 800th hour on June 30, you performed no other work until February of the following year, when you earned 100 hours of Covered Employment. This would allow your benefits to be extended 1 month for the month of February because the 80 hours in the bank added to the 100 hours worked total 180 hours. The remaining 60 hours (180 hours less 120 hours) will be carried over until used. If 12 consecutive months lapse without Covered Employment, your hour bank will be reduced to zero (0). In the same example, had you completed work in June, not returned to work until July of the following year, the 80 hours in the hour bank would have been forfeited and your hour bank would have shown zero (0) hours. You would have to re-establish eligibility by working 500 hours in 12 or fewer consecutive months because 12 months had lapsed. If you do not work in Covered Employment and do not have coverage for 60 months, you must again work 800 hours in 12 or fewer consecutive months to re-establish eligibility.

Reinstatement of Eligibility (Effective August 1, 2002) - Initial Eligibility of Helpers

If you are an Employee working as a Helper, you must work 800 hours in Covered Employment in 12 or fewer consecutive months to satisfy the initial eligibility requirements, become a PIBF participant and qualify for benefits.

You become eligible for benefits on the first day of the month in which you complete the 800th hour of Covered Employment for which the contributing Employer is obligated to make PIBF contributions and will continue for 6 months. Your coverage will then continue on a month-to-month basis to the extent described in the following section.

Extending Your Eligibility (Helpers)

Your coverage is automatically extended as you continue to do the minimum amount of Covered Employment required to maintain eligibility. Every 120 hours of Covered Employment provides one (1) month of coverage. In other words, once the initial eligibility requirements have been met, you always have benefit coverage extending for a month if you have at least 120 hours during the current month and preceding months.

Once you satisfy the initial eligibility requirements, you can accumulate up to 1,440 excess hours in Covered Employment in an hour bank maintained on your behalf to provide for future months of coverage.

Reinstatement of Eligibility (Helpers) (Effective August 1, 2002)

If your eligibility for benefits terminates and you have a 12-month gap in Covered Employment, you will forfeit any hours remaining in your hour bank, and you must work at least 500 hours of Covered Employment within 12 or fewer consecutive months to re-establish coverage. Once you have a 60-month gap in coverage, you must work at least 800 hours of Covered Employment within 12 or fewer consecutive months to re-establish coverage, which is the same as the initial eligibility rules of the Plan. The provision for COBRA participants allowing the extension of the time period up to twelve months has been eliminated. Effective February 1, 2018, the extension of eligibility is based entirely on hours worked.

Here is an example, which will help you understand the extension policy:

Example:

You have 800 hours of credited Covered Employment, which you have performed during the period of January 1 through June 30. You earned the 800th hour of work on June 30. Consequently, you became eligible for 6 months of coverage (800 hours divided by 120 hours equals 6 months of coverage with 80 hours remaining) beginning on June 1, since your coverage becomes effective on the first day of the month in which you perform the 800th hour of work. For every 120 hours you work in Covered Employment during the following months, your eligibility will be extended one month. Unused hours will be carried forward and added to future hours worked.

Now, suppose that after working the 800th hour on June 30, you performed no other work until February of the following year, when you earned 100 hours of Covered Employment which would allow your benefits to be extended 1 month for the month of February because the 80 hours in the bank added to the 100 hours worked total 180 hours. The remaining 60 hours (180 hours less 120 hours) will be carried over until used. If 12 months lapse without work, the account will be reduced to zero (0). In the same example, had you completed work in June and not returned to work until July of the following year, the 80 hours in your hour bank would have been forfeited, and your account would have shown zero (0) hours. You would then have to re-establish eligibility by working 500 hours in 12 or fewer consecutive months because 12 months had lapsed. If you do not work in Covered Employment and do not have coverage for 60 months, you must again work 800 hours in 12 or fewer consecutive months to re-establish eligibility.

Termination of Eligibility For Journeymen & Helpers

Your coverage will cease on the earliest of the following dates to occur subject to your right, if any, to continue coverage under COBRA or to extend coverage under the Plan following retirement or disability: (1) the first day of the month for which you fail to have sufficient hours in Covered Employment to maintain coverage; (2) the date the Plan or Fund is terminated or amended to exclude your coverage; (3) the date of your death; and (4) for a qualified military service leave of absence that exceeds 31 days, the first day of the month for which a required self-payment is not paid timely.

Reciprocal Eligibility

The Trustees have entered into certain "Reciprocal Agreements" with the Trustees of other welfare benefit trust funds which permit Employees to elect to have contributions made to the other Funds transferred to PIBF (also called your "Home Fund") or vice versa under certain circumstances. If you are working or have worked in another local Union's geographic jurisdiction, and your Employer is bound by a Collective Bargaining Agreement to make contributions to another trust fund similar to that of this Fund, you may obtain, upon request to PIBF,

additional information about the existence and requirements of any Reciprocal Agreement pertaining to such employment and the transfer of your work hours and contributions. If hours and contributions are transferred from another fund to PIBF, PIBF will post the transferred hours for the month earned as reported by the other fund. In order to have your work hours and the contributions transferred to your Home Fund, you must make a written request to PIBF and the other fund. The number of transferred hours to be credited to you by PIBF will be determined by dividing the total dollar amount of your Employer's contributions received by PIBF in connection with employment during a particular month by the average hourly contribution rate in effect for Covered Employment under this Plan. The conversion rate will be determined by the Trustees on an annual basis. Your hours are credited based on contributions received by the Fund from your Employer. In the event you do not receive credit for hours worked because your Employer failed to timely remit contributions on your behalf, you may be entitled to credit upon furnishing to the Fund Office your recent paycheck stubs showing the hours you worked during the applicable period.

Disability Provision – Posting of Hours

If you become "Totally Disabled" while covered by the Plan as an active Employee, you will be credited with Covered Employment to the extent described in this Section, solely for the purpose of qualifying for coverage under the Plan. "Total Disability" or "Totally Disabled" means that you are unable to work in Covered Employment or any kind of work because of an illness or injury. You will also be considered Totally Disabled if you are eligible for and entitled to benefits under any worker's compensation or occupational disease law. If you qualify under this provision, you will be entitled to a posting of 40 hours of Covered Employment per week of Total Disability, not to exceed 8 hours a day or a maximum of 720 hours. Hours will only be posted during the months you are eligible for benefits. To re-qualify for this disability provision after you have received the maximum service credit or your Total Disability has ended, you must re-qualify for active eligibility due to hours worked.

In order to receive this service credit, you must make a written request and include adequate documentation in support of your Total Disability, with the PIBF office within 6 months or 180 days following the later of the release to return to work date provided by your attending physician or the date your coverage under the Plan terminates or would terminate due to insufficient hours worked without regard to COBRA or hours credited under this provision.

Dependents Eligibility

For PIBF purposes, the term "Dependent" shall include only the following:

a. Your lawfully married spouse, provided you are not legally separated or divorced.
b. Your child, stepchild or child who is legally adopted by or placed for adoption with you, who is not yet age 26;
c. A child for whom you have a legal guardianship, who is not married and has never been married, does not qualify for coverage as an Employee, is under age 19 and dependent upon you for support, provided all of the following requirements are satisfied:

   (1.) A properly executed guardianship document evidencing legal guardianship must be provided to the Fund office; and
   (2.) One or both of the biological parents must be incarcerated or deceased; and
   (3.) The guardianship papers must clearly indicate that sole managing and possessory guardianship has been given to you or your lawfully married spouse and requires the guardian to maintain health coverage for the child.

Under the Affordable Care Act (ACA), your children from the age of 19 through the last day of the month they turn 26 are eligible for "Coverage" under your plan provided the necessary annual open enrollment forms are completed. If the dependent child does not qualify under provision of the ACA, they may qualify if they are in full-time attendance (carrying 12 credit hours per semester) at an institution of higher learning and who are dependent upon you for support as outlined above. Full-time students enrolled for the fall term (August - December) would qualify for dependent coverage through January 31. Full-time students enrolled for the spring term (January - May) would qualify for dependent coverage through August 31. A student's Dependent status will immediately terminate upon the happening of any of the following: (1) the college-age Dependent encounters a break from full-time status exceeding 12 consecutive months; (2) on their 25th birthday;(3) the date they graduate and do not continue their education on a full-time basis; (4) at such time during any term or semester the student drops classes resulting in less than 12 credit hours; (5) they marry or otherwise cease to qualify as a Dependent under the Plan. PIBF requires that

full-time student verification letter from, the Registrar's office of the school, be submitted for each term or semester (letter must be dated after the term or semester begins). Pre-registration letters, class schedules, etc., cannot be used to establish eligibility. The Pipeline Industry Benefit Fund should be notified immediately when a student's Dependent status changes. A Dependent college student's coverage under the parent's plan will be extended up to one year if the student takes a medically necessary leave of absence. The PIBF follows rules established by Public Law 110-381 which is titled Michelle's law. More information concerning Michelle's Law is found in the definitions in the back of this SPD.

d. An unmarried child, stepchild, or child who is legally adopted by or placed for adoption with you before age 26, who, on the date of his/her eligibility as your Dependent child would otherwise terminate because of the attainment of age 26, is both (a) incapable of self-sustaining employment by reason of mental deficiency or physical handicap, and (b) primarily dependent upon you for support and maintenance, provided proof of such incapacity and dependency is furnished to PIBF within 31 days of the child's attainment age 26. The coverage of such a child shall continue as long as the incapacity and dependency continue. The Trustees may require proof of the child's continuing disability and dependency as often as it deems necessary.

e. An alternate recipient, which is a child of an Employee who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enroll in the Plan. QMCSOs include National Medical Support Notices issued by state agencies.

Date Dependents Become Eligible

Your dependents shall become eligible for PIBF coverage on the latest of (1) the date you become covered; (2) the date you acquire the Dependent; or (3) if applicable, the date specified in a QMCSO.

Before claims are paid on your dependents, PIBF requires that you enroll your Dependents by submitting a copy of the following documents (as applicable) to the PIBF office:

- Your marriage license
- Your children's birth certificates
- Previous divorce decree or child custody agreement regarding health insurance responsibility
- Other necessary documents required by PIBF

Dependents who no longer qualify for coverage as a Dependent may be eligible for COBRA continuation coverage

Changes in Dependent Status

You must notify the PIBF office immediately upon any change in your Dependent's status, including but not limited to divorce, legal separation, birth, death, adoption, marriage or attainment of the limiting age. Failure to notify the PIBF office within 60 days following a "qualifying event" for purposes of COBRA coverage continuation, due to the Employee's divorce or legal separation, or loss of Dependent child status, will result in the forfeiture of the right to elect COBRA coverage with respect to the qualifying event.

You and your Dependents will be responsible for reimbursing PIBF for any overpayments that are made due to the failure of you and your Dependents to advise the PIBF timely of any changes in Dependent status.

Dependents will be given special enrollment rights in the following instances to the extent required by HIPAA. If a Dependent does not enroll in the Plan when first eligible because of other health coverage under COBRA or another health plan, he may enroll for coverage under this Plan during a special enrollment period in the following two instances: (1) when COBRA coverage is exhausted; or (2) when the other health coverage terminates because he is no longer eligible or because his employer has stopped contributing toward the other coverage (but not due to nonpayment of premium or for cause). In order to enroll during a special enrollment period, a written request for enrollment, with any required documentation, must be filed with the PIBF office within 30 days after exhaustion or termination of the other coverage, and the Dependent will be enrolled for coverage under the terms of this Plan retroactive to such date. In no event will these special enrollment rules operate to provide a Dependent with a later effective date of coverage than he would otherwise be entitled to receive under the Plan's general enrollment rules.

Termination of Dependents Eligibility

Your Dependent's coverage will end on the earliest of the following dates subject to the right, if any, to continue coverage under COBRA or to extend coverage under the Plan following your retirement, death or disability:

- The date your PIBF coverage ends other than by reason of your death; or
- If your PIBF coverage ends due to your death, or the date your active coverage would have ended had you ceased working immediately prior to death; or

- The date, or for a Dependent child, the end of the month in which he/she is no longer an eligible Dependent as defined by Dependent eligibility rules; or
- The date specified in a QMCSO; or
- The date the Plan or PIBF is terminated or amended to exclude coverage for the Dependent; or
- The date of the Dependent's death

Eligibility for Retired Participants & Permanently & Totally Disabled Participants

Initial Eligibility

You are eligible to purchase retiree medical coverage under the Plan, for yourself and your eligible Dependents, as described in this Section if you retire from active Covered Employment, receive a pension provided by the Pipeline Industry Pension Fund and satisfy one of the following requirements:

- You must have at least 20 years of credited service under the Pipeline Industry Pension Fund earned after January 1, 1965, and at least two vesting years (a vesting year equals 400 hours minimum) of the 20 or more years of credited pension service must have been earned within the five years immediately preceding your retirement; or,

- You must have at least 25 years of credited service and show proof of continuous coverage for 24 months prior to retirement; or,

- Effective January 1, 2017, plan participants who retire with less than 20 years of credited service can earn the 20 years of credited service after retirement. The plan participant must have at least 400 hours in each of the two years prior to earning the 20 years of credited service. Other rules to obtain retiree coverage remain in effect.

- Effective January 1, 2017, plan participants with over 20 years of credited service at retirement who did not qualify for retiree coverage at retirement (because they did not meet the requirement of at least two years with 400 hours in each year earned within the five years immediately preceding retirement) can earn coverage by working two years with at least 400 hours in each year after retirement. Other rules to obtain retiree coverage remain in effect.

The self-payment amount required for retiree coverage will be determined by the Trustees from time to time. The self-payment is payable on a monthly basis. If a self-payment is not paid timely, the extended coverage will terminate as of the last day of the month for which self-payment was made timely and cannot be reinstated.

Opt-Out/Opt-In Feature

If you qualify for retiree coverage at the time of retirement as described above and are not yet eligible for Medicare, you and your Dependents, or only your Dependents, can elect to opt out of the retiree coverage at that time. You and your Dependents can opt back in the month you become eligible for Medicare. Your Dependent spouse can also opt back in on the date your Dependent spouse becomes eligible for Medicare. If you and your Dependents are eligible for but do not elect retiree coverage on the date of retirement, you and your Dependents may do so later at any time provided you and your Dependents have maintained 24 months of uninterrupted health care coverage prior to requesting to opt into the retiree health plan.

(Please refer to the prescription drug benefit section for information on opting out of that program.)

Continuation of Eligibility

You and your Dependents will remain eligible for the retiree coverage as long as you continue to receive a pension from the Pipeline Industry Pension Fund. If you return to work, the eligibility of you and your Dependents will be affected by the following rules:

1. If you return to work in the pipeline industry for a non-contributing employer, without written approval from a Union organizer or business agent notifying PIBF that you are assisting in organizing, your retiree medical coverage and your Dependents' retiree medical coverage will terminate upon such employment and cannot be reinstated; or

2. If you return to work in the pipeline industry for a contributing Employer as a welder, journeyman, helper or pipe foreman or welder foreman, your retiree medical coverage and your Dependents' retiree medical coverage will not be disrupted. You will not have your coverage as an active Employee reinstated; however, your required monthly self-payment will be waived for each month for which you worked or had accumulated enough hours in Covered Employment to qualify for coverage as an active Employee.

3. If you return to work in another industry, you would be eligible for continued retiree medical coverage.

Dependents Eligibility

All eligible Dependents of a retired Employee who qualify for retiree coverage on a self-payment basis following retirement will remain eligible for this extended coverage as long as the retired Employee remains covered. Coverage terminates if they no longer qualify as the Employee's Dependent. If a retired Employee with extended coverage dies, the surviving spouse, if covered at the retiree's death, may continue to self-pay for retiree coverage beyond the end of the month in which the death occurs, in the amount determined by the Trustees, until the earlier of death or remarriage or until the first day of the month for which a required self-payment is not made timely. Dependent children, if any, who are covered at the retiree's death, may continue their retiree coverage on a self-payment basis beyond the end of the month in which the death occurs, in the amount determined by the Trustees, until they cease to qualify as a Dependent. The dependent coverage also terminates with the termination of the surviving spouse's coverage. The spouse and dependent children can continue their coverage after a qualifying event under COBRA for up to 36 months.

Coverage for Retired Participants & Their Dependents

As of January 1, 1992, the retired employee, his legal Dependent spouse at the time of his retirement, and his legal Dependent children at the time of his retirement will be covered for medical benefits and prescription benefits.

For the retired Employee or his Dependent spouse, PIBF will provide secondary medical coverage to Medicare Part A and Part B and primary prescription coverage as an approved substitute for Medicare Part D. Eligible persons who are retired or disabled and eligible in Part A and Part B of Title XVIII of the Social Security Amendments of 1965 (more commonly known and described as "Medicare") by reason of attained age, qualifying disability, or End-Stage Renal Disease will be required to pay a higher monthly self-payment for their retiree medical coverage.

The extended medical coverage available to eligible Retired Employees and their Dependents does not include coverage for the following:

- Death Benefit
- Dismemberment and Loss of Sight Benefit
- Weekly Disability Benefits
- Hearing Aid Benefits
- Welding Hood Lenses Benefit
- Laser Eye Surgery Benefit
- Dental Benefits
- Vision Benefits

Coverage Continuation Under COBRA

Introduction

This section of your SPD contains important information about your right to COBRA continuation coverage, which is a temporary extension of health coverage under the plan on a self-payment basis. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. The COBRA requirement and your rights under COBRA are summarized below. The Plan will provide and administer such coverage in accordance with the requirements under COBRA.

There may be other options available to you and your family members when group health coverage is lost under PIBF. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower cost on the monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Plan when coverage otherwise would end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose health coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries. A qualified beneficiary also includes any Dependent child who is born to, adopted by or placed for adoption with a covered Employee during a period of COBRA coverage. If a qualified beneficiary with COBRA coverage has a Dependent who was eligible but did not enroll for COBRA when the qualified beneficiary enrolled because the Dependent had other health coverage and lost the other coverage due to exhaustion of COBRA, loss of eligibility (but not due to nonpayment of premium or for cause), or the termination of employer contributions for the other

coverage, the qualified beneficiary may add the Dependent to his COBRA coverage for the remainder of the COBRA period. The qualified beneficiary must add such Dependent by written notice to PIBF within 30 days after the Dependent lost the other COBRA or health coverage. If COBRA ends for a qualified beneficiary, it will also end for any of his family members who are covered but are not qualified beneficiaries in their own right. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you will lose your health coverage under the Plan because either one of the following qualifying events happens:

1. You do not work enough hours of employment to maintain eligibility, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your health coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse does not work enough hours of employment to maintain eligibility;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare (Part A Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose health coverage under the Plan because of any of the following qualifying events:

1. The parent-employee dies;
2. The parent-employee does not work enough hours of employment to maintain eligibility;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to one of the contributing employers and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee is a qualified beneficiary with respect to the bankruptcy. The retired Employee's Dependent spouse, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or insufficient hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or entitlement of the employee to Medicare (Part A, Part B, or both), the Plan Administrator will notify the Employee and Dependents of the right to elect COBRA within 30 days of the resulting loss of coverage (subject to a reasonable extension of time if needed.)

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you and your Dependents must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator, Renée Vause. The notice must include the names of the Employee and qualified beneficiary(ies), the type of qualifying event and date it occurred, and if applicable a copy of the divorce decree or written proof of legal separation. Failure to do so may result in a forfeiture of the right to elect COBRA. The Plan Administrator will notify the affected individuals of the right to elect COBRA within 30 days after receiving the required notice of the qualifying event (subject to a reasonable extension of time if needed.) Notice given to the Employee or a Dependent spouse is deemed to be notice to all affected Dependent children living with the Employee or spouse.

If the Employee or Dependent fails to give timely notice of a qualifying event as required and the Plan erroneously pays a claim that should not have been paid because coverage terminated due to the qualifying event, the Employee and/or Dependent will be obligated to reimburse PIBF for the erroneous claim paid. If they fail to do so, PIBF may deduct the amount owed from other benefits payable to them.

Once the Plan Administrator receives notice that a qualifying event has occurred, specific information regarding when and how to elect COBRA continuation coverage will be sent to each of the

qualified beneficiaries. In order to elect COBRA, the qualified beneficiary must sign and return an election form to the Plan Administrator within 60 days after the later of (1) the date coverage terminates due to the qualifying event or (2) the date he is notified of the right to elect COBRA. If elected, COBRA will be retroactive to the date of termination.

COBRA continuation coverage is a temporary continuation of health coverage. When the qualifying event is the death of the employee, entitlement of the employee to Medicare (Part A, Part B, or both), the employee's divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or insufficient hours of employment, COBRA continuation coverage lasts for up to 18 months. If the Employee has an end of employment or insufficient hours qualifying event after first becoming entitled to Medicare benefits, the period of COBRA available to his Dependents will be 36 months from the date he first became entitled to Medicare or 18 months from the end of employment or reduction of hours, whichever is longer. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If an Employee or Dependent is receiving COBRA by reason of a termination of employment or insufficient hours qualifying event, and the Employee or Dependent with COBRA is determined by the Social Security Administration ("SSA") to be totally disabled at any time during the first 60 days of COBRA continuation coverage and notice of such disability is provided to the Plan Administrator in a timely fashion, the Employee and each family member with COBRA by reason of the same qualifying event can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, or if earlier, through the last day of the month which includes the 30th day after a final determination by SSA that the individual is no longer disabled. In order to qualify for this extension, the Plan Administrator must be notified of the Social Security Administration's determination and be provided with a copy of such determination within 60 days of the date of the determination (or the first 60 days of COBRA coverage if later) and before the end of the 18-month period of COBRA continuation coverage. The covered individuals must also notify the Plan Administrator of any SSA determination that the disabled individual is no longer disabled within 30 days after a final determination.

This notice should be sent to the Plan Administrator, Renée Vause, 4845 S. 83rd East Avenue, Tulsa, OK 74145-6909. You should include a copy of your Medicare card to verify coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If any qualified beneficiary experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family who are qualified beneficiaries with COBRA can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if there is a second qualifying event due to the former employee's death, Medicare entitlement (Part A, Part B, or both), or divorce or legal separation, and to a dependent child if there is a second qualifying event due to the child ceasing to qualify as a Dependent under the Plan. In all of these cases, the Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event.

This notice must be sent to the Plan Administrator, Renée Vause, 4845 S. 83rd East Avenue, Tulsa, OK 74145-6909. You should include documentation to substantiate the second qualifying event.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Employee/Dependents Self-Payment Privileges – Continuation Coverage for Employee/Dependents Who Lose Eligibility

Once declared eligible for COBRA continuation coverage, the person meeting these criteria will be required to make self-payments to PIBF in an amount determined by the Trustees in order to maintain eligibility for benefits on the following basis:

The self-payment cannot exceed the actual cost of the group health coverage plus an additional amount permitted by law.

- The first self-payment must cover the cost of COBRA coverage from the date coverage would otherwise terminate through the end of the month in which payment is made, and it must be made no later than 45 days after the date COBRA is elected.

- All subsequent self-payments are payable monthly and due on the 1st day of the month, subject to a 30-day grace period following the due date.

It is the responsibility of you and your Dependents to make timely payments. PIBF is not required to bill you.

Notwithstanding the 18, 29 and 36 month periods described above, COBRA coverage will terminate earlier upon the 1st, if any, of the following: (1) the first day of the first month for which you or your Dependent fails to pay timely the required COBRA self-payment; (2) the date, after COBRA is elected, on which you or your Dependent 1st becomes covered under another group health plan that does not have a pre-existing condition limitation or exclusion that affects you (or if it does, the date you are no longer affected by it); (3) the date your Employer stops contributing to PIBF and makes other group health plan coverage available, or starts contributing to another multiemployer plan that makes group health plan coverage available, to a significant number of its employees who were formerly covered under PIBF; and (4) the date the Board of Trustees terminates the Plan and all group health plans and no longer provides group health coverage to Employees.

COBRA coverage is always optional, and each qualified beneficiary may make an independent election to receive it. The cost of COBRA must be paid entirely by the qualified beneficiary. The health benefits available during COBRA will be the same as those provided to similarly situated participants with respect to whom a qualifying event has not occurred.

If You Have Questions

If you have questions about your COBRA continuation coverage, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, you should contact the Director at the Pipeline Industry Benefit Fund, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa. For more information about the Marketplace, visit www.healthcare.gov.

Certificate of Creditable Coverage

In the event health coverage under the Plan ceases for you or your Dependent for any reason, you and your Dependent also have the right to request a Certificate of Creditable Coverage even if a Certificate of Creditable Coverage has been previously provided to you by contacting the PIBF office.

Coordination & Non-Duplication of Benefits

If you or your eligible Dependents are covered under any Other Plan that provides benefits for part or all of the medical expenses covered under this Plan, you and your Dependents must promptly notify PIBF of the other coverage, and the Plan's Coordination of Benefits rules will apply.

"Other Plan" means any of the following group health coverage providing benefits or services for hospital, medical, prescription, dental or vision care: (a) group or blanket insurance or arrangement of coverage for individuals in a group (whether insured or uninsured), including employer plans, Blue Cross and Blue Shield plans and HMO plans; (b) prepayment coverage provided on a group basis; (c) any coverage under a labor-management trustee plan, union welfare plan, employer organization plan or employee benefits organization plan; (d) coverage under governmental programs or required by statute other than a state plan for medical assistance provided under Medicaid, and except as otherwise prohibited by law; (e) automobile medical insurance including uninsured or underinsured motorist coverage, no-fault insurance coverage, or medical payment coverage; and (f) casualty or liability coverage.

Coordination of benefits ("COB") is a concept of anti-duplication. COB provides that if an individual is covered by two or more group health plans, the amount of benefits payable by the PIBF Plan and the Other Plan will be coordinated so that the total amount paid will not exceed 100% of the medical expense incurred. In no event will this Plan's payment exceed the amount, which would have been paid if there were no Other Plans involved.

Benefits payable under another Plan include the benefits that would have been payable even if no claim was actually filed.

Payment is made on a primary-secondary basis. The primary plan will calculate its benefits and pay first without regard to the Other Plan. The secondary plan will then reduce benefits as needed, taking into account the amount paid by the primary plan and any other secondary plan primary to it, so that the total benefits paid or provided by all plans do not exceed 100% of the medical expense.

In the event this Plan is the secondary plan, and the primary plan requires services to be performed by their In-Network providers, and the patient chooses to go Out-of-Network which would not be covered by the primary plan; or the patient does not follow the primary plan's guidelines (i.e., failure to obtain prior approval when necessary) which results in the primary plan denying coverage for such services, PIBF will not consider the charges in full. The secondary benefits provided by PIBF in instances such as this will be subject to the Plan's deductible and covered at 50%.

When another primary plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an allowable expense and a benefit paid.

Order of Benefits Determination

The rules establishing the order of benefits determination are as follows:

Non-Dependent/Dependent Rule: The plan that covers the person as an employee or retiree and the plan providing coverage due to employment in which he/she has last worked is the plan that pays first. This shall be the "primary plan." The plan that covers the person as a dependent is the plan that pays second and will be the "secondary plan."

1. Dependent Child Covered Under More Than One Plan Rule: If the parents are married or not separated (whether or not they have ever been married) or if there is a court decree awarding joint custody without specifying that one parent has responsibility for the child's health coverage, the primary plan is the plan of the parent whose birthday (excluding the year of birth) occurs earlier in a calendar year. If both parents have the same birthday, the plan that has covered either parent longer is the primary plan.

2. When parents are divorced or separated, the order of benefit determination is:
   A. The plan of the parent having custody pays first.
   B. If the parent having custody has remarried, the order is:
      1) The plan of the parent having custody
      2) The plan of the spouse of the parent having custody
      3) The plan of the parent not having custody
      4) The plan of the spouse of the non-custodial parent

However, when a court decree names and directs one of the parents to be responsible for the child's health care expenses, the plan of that parent will pay first and will supersede any order given here. If primary health insurance is not provided by the parent specified as responsible for the child or children's medical expenses as ordered by the court, PIBF will estimate primary benefits as if there had been a policy in place and allow only secondary coverage, unless the PIBF participant can provide sufficient evidence that the person ordered to provide health insurance is unable to meet the obligation.

If the above rules do not determine which plan will calculate and pay its benefits first, then the plan that has covered the patient for the longer period of time will determine its benefits before a plan that has covered the patient for a shorter time.

There is one exception to this rule:
A plan that covers a person as an employee who is neither laid off nor retired or as that person's dependent, will determine its benefits first, even if it has covered the eligible person for the lesser time, and a plan that covers the same person as a laid-off or retired employee or as that person's dependent will be the secondary plan. Coverage provided to a person as a laid-off or retired employee and as a dependent of an actively working spouse will be determined under the Non-Dependent/Dependent rule.

In addition, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the benefits of the plan, which covers the person as an employee, will be determined before the benefits under the continuation coverage of COBRA.

3. Any plan that does not contain a coordination of benefits provision is automatically the primary plan.

4. Medicare Provisions. Eligible persons who are retired or disabled are required to enroll in Part

A and Part B of Title XVIII of the Social Security Amendments of 1965 (more commonly known and described as "Medicare") in the event they become entitled to such coverage by reason of attained age, qualifying disability, End-Stage Renal Disease, or any other reason under law. The COB rules described above also are intended to apply whenever the Other Plan is Medicare, unless and to the extent such coordination would violate Medicare and its regulations. Coverage under this Plan will be coordinated with Medicare for an individual who is eligible for Medicare whether or not he is enrolled.

Right of Reimbursement and Subrogation

PIBF would be considered the secondary carrier where medical expense payments are provided through, or payable by, any automobile insurance liability, uninsured motorists or similar policy, including liability coverage, from any third party for injury on their premises, or for their acts.

Whenever PIBF has been or is providing hospital, medical, dental, vision, or disability benefits ("Benefits"), as a result of the occurrence of any injury, sickness, or death, that results or is alleged to result from a third party's negligence or wrongful action, or for which benefits may be payable under a worker's compensation law, the Plan will have the subrogation, reimbursement and recovery rights described in this Section for the amount of Benefits paid. The Plan will be subrogated to all claims, demands, actions and rights of recovery which the covered person has against any entity, including but not limited to third parties and insurance carriers (including the covered person's insurer), arising out of any claim or cause of action which may accrue because of the alleged negligence or wrongful action of the third party, or with respect to payment of worker's compensation benefits, for the amount of Benefits paid by PIBF. The Plan may condition payment of Benefits for such charges upon the covered person's execution of the Plan's subrogation, assignment, and reimbursement agreement (Reimbursement Agreement), certifying that: (1) no other payments have been made in satisfaction of the claims; (2) the claims are disputed; (3) the responsible party is withholding payment pending resolution of the dispute; and/or (4) any additional provisions required by the Plan. If the Plan does not require the covered person to sign such agreement prior to receiving payment of Benefits, it may do so at any time thereafter pending the Plan's recovery of Benefits.

In addition, any Benefits paid by the Plan for which there may be third-party liability (or worker's compensation benefits payable) will be made on the condition and with the understanding that the Plan will be reimbursed from any recovery and that the covered person is obligated to comply with the following requirements:

(1) To reimburse PIBF out of the first proceeds of any recovery or settlement payable by the responsible third party or its insurer or the covered person's insurer with respect to such third party liability (e.g., under uninsured motorist or homeowner's insurance coverage), or pursuant to worker's compensation law, whether by way of litigation, settlement or otherwise and regardless of how the proceeds are characterized. The Plan's prior right of recovery will be a prior lien against any such proceeds, and the Plan's right may not be defeated or reduced by the application of any "make-whole" or other doctrine that purports to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages;
(2) To reimburse PIBF from any gross amount recovered by the covered person before payment of attorneys' fees and costs;
(3) To cooperate fully with the Plan and to execute and provide all necessary documents and information requested by the Plan to protect, enforce and/or facilitate its subrogation, reimbursement and recovery rights;
(4) Not to take any action that would interfere with the Plan's rights described in this Section;
(5) To recognize that the Plan has no obligation to pay to the covered person or his attorney any amounts expended by them in fees and costs of litigation in pursuing claims against others;
(6) To reimburse the Plan and make it whole for all attorneys' fees and costs expended by the Plan in pursuing litigation or other action, in whatever forum, to enforce the terms of the Plan and its rights under this Section;
(7) To notify the Plan before starting legal action or filing suit against a third party that is allegedly liable (or an insurer with respect thereto), to make no settlement and to grant no release to any third party or insurer without the prior written consent of the Plan;
(8) To acknowledge the Plan's rights and allow the Plan to intervene in any claims or action taken by or on behalf of the covered person against an allegedly liable third party or insurer; and
(9) To protect the Plan's rights under this Section and do nothing that would in any way prejudice such rights.

If a covered person refuses or fails to comply with his obligations or cooperate in any manner as required under this Section or to reimburse the Plan after receiving payment of sums due to the Plan, the Plan may institute legal action to recover benefits paid and/or withhold payment of other benefits due under the Plan to or for the covered person for related or unrelated claims to recover the amounts owed to the Plan, until the covered person complies, or the amounts owed to the Plan are fully recovered.

General Plan Exclusions

Notwithstanding any other provision of this booklet to the contrary, PIBF does <u>not</u> cover, and no benefits are payable, for any of the following expenses, treatments or conditions, nor do charges incurred for any of them count toward satisfaction of any deductible or out-of-pocket limit:

1. Any treatment which is the result of an accident, personal injury, occupational disease, event or occurrence covered under any Worker's Compensation Act, Jones Act, or similar laws, whether or not any payment is received under these laws.

2. Any expense or change for services or supplies which is not provided in accordance with generally accepted professional standards; clinical trials or for experimental or investigative treatment which has not been proven to be safe and effective, or which is not medically necessary unless specifically covered as a wellness benefit.

3. Any charges incurred for the diagnosis of obesity, weight control, including all diet programs (diet pills and injections). Effective January 1, 2018, weight loss medications can be covered when certain criteria are met. These criteria include Plan established guidelines for diagnosis of Morbid Obesity – Body Mass Index of 35 or higher with co-morbidities (serious medical conditions) such as pre-diabetes, diabetes, high blood pressure, sleep apnea, lower extremity joint pain, shortness of breath; participation in a physician-supervised diet program; psychological evaluation and other guidelines established by the Plan including prior authorization by Sav-Rx clinical department and may be subject to step therapy.

4. Treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial repair of maxillary and mandibular resections, osteoplasty or other related surgery of the jaw.

5. Expenses related to reversal of a vasectomy or tubal ligation.

6. Expenses related to the diagnosis or treatment of sterility or infertility, including, but not limited to, artificial insemination, in vivo or in vitro fertilization, pre-conception genetic testing, or other related surgery to establish a pregnancy.

7. Impotence or treatment of sexual dysfunction, including any procedures for a penile prosthesis.

8. Treatment furnished in connection with conditions related to growth disorders, including, but not limited to pituitary dwarfism.

9. Expenses incurred in connection with elective breast reduction surgery, not considered Medically Necessary, including, but not limited to, all hospital, medical, surgical, or prescription drugs, but excluding any procedures required to be covered under the Women's Health and Cancer Rights Act of 1998 or the Department of Health and Human Services ruling for services provided to Transgender individuals effective January 1, 2017.

10. Expenses related to the voluntary termination of a pregnancy.

11. Cosmetic procedures, treatment or reconstructive surgery except when required as the result of an accidental injury, or for repair of congenital defects of newborn children, or for the repair of the effects which result from surgery, as required under the Women's Health and Cancer Rights Act of 1998 or the Department of Health and Human Services ruling for services provided to transgender individuals effective January 1, 2017.

12. Bodily injury or sickness suffered or hospitalization resulting from acts of war.

13. Expenses incurred due to or as a result of willful participation in the commission of a criminal act, felony or illegal occupation, but in no event will this exclusion be interpreted to apply to expenses incurred due to or as a result of acts of domestic violence for which coverage is required to comply with HIPAA.

14. Services performed by a person who lives with you or is part of your family (comprising you, your spouse, or your or your spouse's child, brother, sister, or parent.)

15. Expenses for nursing home, long-term care facility, private duty nurse, custodial care, housekeeping, or group home.

16. Expenses related to pregnancy for dependent children.

17. Charges which are in excess of the Reasonable Expenses Incurred in the geographical area where services or supplies are rendered by a non-PPO provider or the contracted rates for a PPO provider.

18. Services or supplies without a diagnosis of injury or sickness, including, but not limited to, employment physicals and sports physicals or routine drug screening unless and except to the extent specifically covered.

19. Weekly disability benefits for anyone not covered as an active employee, or when eligibility is continued under the COBRA (self-pay) program.

20. Vitamin B-12 injections excluded except for blood-related conditions.

21. Expenses for marital counseling.

22. Expenses for personal hygiene and convenience items (such as, but not limited to, humidifiers, whirlpools, physical fitness equipment or like items), even though a physician may prescribe them.

23. Expense for treatment or prescription drugs related to any type of substance abuse including but not limited to alcoholism and drug abuse with service dates prior to January 1, 2026.

24. Charges for recreational therapy, massage therapy or acupuncture.

25. Charges for the failure to keep a scheduled visit, for completing a claim form, copying of medical records, special reports, registration fees or any taxes or postage.

26. Services (treatment) or supplies to treat hair loss or to restore lost hair.

27. Chelation therapy except for acute arsenic, gold, mercury or lead poisoning.

28. Any treatment for snoring, including surgery.

29. Maintenance, delivery, or set-up fees for durable medical equipment.

30. Supplies or services for which you are not required to pay.

31. Hospitalization for dental care that is not considered Medically Necessary.

32. In-patient confinement for a vasectomy.

33. Routine immunizations or vaccinations not recommended or endorsed by the CDC or ACIP. Immunizations or vaccinations administered to patients not within the age recommendations provided by the CDC or ACIP for the immunization or vaccine.

34. Expense for any service or procedure that is not considered Medically Necessary for the diagnosis submitted or not considered Medically Necessary or the illness or injury being treated.

35. Hygienic equipment or service which is not primarily medical in nature (i.e., toilet seat, bath bench).

36. Services and supplies not primarily medical in nature.

37. Expenses or fees for shipping and handling.

38. Fees incurred for any type of warranty.

39. Charges for replacement of teeth that are not permanent teeth.

40. Charges for dental services and supplies for treatment performed solely for cosmetic purposes.

41. Charges for dental implants or related services.

42. Charges for eyeglass chains, contact lens kit aseptor, contact solution, contact starter kit, glasses cases, glasses cleaner, heating units, initials, insurance, warranties, lens guard, nose pads.

43. Non-emergency ambulance service or ambulance transportation for convenience, including transports for personal convenience or elective transports.

44. Private room difference for a covered hospital admission unless Medically Necessary.

45. Expenses for genetic testing, including, but not limited to, preconception genetic testing (carrier testing), prenatal genetic testing during pregnancy not considered Medically Necessary, pharmacogenomic testing for drug toxicity and response, predictive and pre-symptomatic testing to identify a person's risk of developing a disease or disorder, DNA sequence to identify an individual (for example, paternity), home genetic kits and services, genetic testing and counseling for BRCA 1 and BRCA 2 mutations that does not meet the criteria outlined by ACOG (American Congress of Obstetricians and Gynecologists), and diagnostic genetic tests not being performed to confirm a diagnosis nor directly impacts the individual's medical care and treatment plan.

Legal Notices

YOUR RIGHTS UNDER THE FAMILY & MEDICAL LEAVE ACT (FMLA) OF 1993

QUALIFIED MILITARY SERVICE

REQUIREMENTS UNDER THE WOMEN'S HEALTH & CANCER RIGHTS ACT

STATEMENT OF RIGHTS UNDER THE NEWBORN & MOTHERS HEALTH PROTECTION ACT

PERMITTED USES AND DISCLOSURES OF PHI

EXAMINING AND OBTAINING ADDITIONAL PLAN DOCUMENTS

Your Rights Under the Family & Medical Leave Act of 1993

Employees may be eligible for FMLA leave if they have worked for a Contributing Employer for at least one year, and for 1,250 hours over the previous 12 months. See the General Definitions section for an explanation of what constitutes a Contributing Employer.

Coverage While On Family & Medical Leave

If you become eligible for FMLA leave according to the Family and Medical Leave Act of 1993 and the Plan's FMLA policies and administrative procedures, your health coverage under the Plan may be continued at no cost for up to 12 weeks in a 12-month period (26 weeks to care for a covered service member) subject to the following:

- Your Employer is required to pay contributions on your behalf as established by the Trustees;
- Your Employer is subject to FMLA;
- Your Employer files the appropriate notification and certification forms with PIBF.

Reasons for Taking Leave

FMLA provides for unpaid leave to be granted for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform his/her job.
- For a "qualifying exigency" that arises because the Employee's spouse, son or daughter, or parent is on active duty or has been notified of a call or order to active duty in the Armed Forces in support of a contingency operation; or
- To care for the Employee's spouse, son or daughter, parent or next of kin who is a covered service member with a serious injury or illness.

Advanced Notice & Medical Certification

The Employee ordinarily must provide 30 days advance notice when the leave is "foreseeable." An Employer may require medical certification to support a request for leave because of a serious health condition and may require second or third opinions (at the Employer's expense) and a fitness for duty report to return to work. Taking of leave may be denied if these requirements are not met. Generally, a "serious health condition," as defined under FMLA, is an illness, injury, impairment, or physical or mental condition that involves any period of incapacity or treatment in connection with inpatient care in a hospital, hospice, or residential medical care facility, or any period of incapacity of more than three (3) calendar days that involves the continuing treatment by a health care provider, or continuing treatment by a health care provider for a chronic or long-term health condition that is incurable or so serious that if untreated will result in a period of incapacity for more than three (3) calendar days. If you are considering taking Family and Medical Leave, you and your Employer should contact the Fund Director to receive a copy of the Plan's FMLA policies and administrative procedures and the necessary forms to determine your rights and obligations to receive health coverage during your FMLA leave.

Qualified Military Service

If you are an Employee, and you take a leave of absence for Service in the Uniformed Services that is protected under the federal law known as USERRA, any service you have earned and any contributions credited to your benefit for initial or continuing eligibility (including hours accumulated in an hour bank) will be protected to the extent required by USERRA and the Plan's related policies and procedures. You are obligated to notify PIBF as soon as you are called up for Service in the Uniformed Services, or as soon thereafter as is reasonably possible, to ensure protection of your rights under USERRA. If you are discharged from your Service in the Uniformed Services less than honorably or do not return to Covered Employment or submit application to return to Covered Employment with a Contributing Employer (within 90 days following the date of release from such Service in the Uniformed Services) you will forfeit the right to reinstatement under USERRA, and the treatment of any service and contributions credit, hour bank and Plan coverage that you and your Dependents had immediately prior to such service will be governed by the Plan's initial and continuing eligibility and reinstatement of eligibility rules.

Definitions

- "Health coverage" means the medical benefits offered by the Plan for which a person is eligible at the time Service in the Uniformed Services begins and are subject to change as a result of plan modification.
- USERRA is an acronym for the Uniform Services Employment and Reemployment Rights Act of

1994 (including any amendments to USERRA and any interpretive regulation or rulings).

- "Service in the Uniformed Services" means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

- "Uniformed Services" means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

USERRA and Continuation of Health Coverage

- If you are an Employee covered by the Plan and Health Coverage for you and your Dependents ends because of your Service in the Uniformed Services, you may elect to continue such Health Coverage for you and your Dependents, as required by USERRA, until the earlier of:
  1. The end of the period during which you are eligible to apply for re-employment after your Service in the Uniformed Services ends; and
  2. 24 consecutive months after the day your Service in the Uniformed Services begins. (It was extended.)

- To continue Health Coverage, you must self-pay the required premium for you and your Dependents unless Service in the Uniformed Services is for fewer than 31 days. PIBF will administer your right to continue Health Coverage under USERRA in accordance with the same administrative rules and procedures that it uses for continuing coverage under COBRA to the extent they do not conflict with USERRA. The USERRA premium shall be equal to the COBRA premium. Any coverage extended under USERRA will be concurrent with the period of extended coverage required under COBRA.

- Continued Health Coverage under USERRA for you and your Dependents will end at midnight on the earliest of:
  1. the day the Plan is terminated;
  2. the last day of the last period for which a required premium is paid timely;
  3. the day you again become covered under the Plan as an Employee;
  4. the last day of the period during which you are eligible to apply for re-employment (in accordance with USERRA) or 24 consecutive months after your Service in the Uniformed Services began.

Conflict Resolution

In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply.

Requirements Under the Women's Health & Cancer Rights Act

Under Federal Law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy must include medical and surgical benefits for breast reconstructive surgery in connection with a mastectomy.

These benefits must at a minimum provide for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Benefits payable for such coverage are subject to the Plan's appropriate cost control provisions such as deductibles and coinsurance and overall limits.

Statement of Rights Under the Newborns & Mothers Health Protection Act

This Plan, to the extent it provides maternity benefits for covered Employees and Dependent spouses (but not for Dependent children), will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician's assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal Law, this Plan may not set the level of benefits or out-of-pocket costs so that any

later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the plan may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

COMPLIANCE WITH PRIVACY REGULATIONS AND OTHER REQUIREMENTS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNT-ABILITY ACT

Permitted Uses and Disclosures of PHI

The Plan may use and disclose PHI, without the consent or authorization of the individual to whom it relates, for purposes of the individual's health care treatment, payment, and health care operations, as follows:

1. **Health Care Treatment:** Health care treatment means the provision, coordination or management of health care treatment and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and referrals of a patient for health care from one health care provider to another.

2. **Payment for Health Care:** Payment for health care means activities undertaken to obtain premiums, to determine or fulfill the Plan's responsibility for coverage and provision of health care benefits, or to obtain or provide reimbursement for the provision of health care. These activities shall also include the following:

    - Determination of eligibility, coverage, and cost-sharing amounts (including cost of a benefit, Plan maximums and co-payment, and coordination of benefits);

    - Adjudication of health benefit claims (including appeals and other payment disputes);

    - Subrogation of health benefit claims;

    - Establishing contributions;

    - Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), related health care data processing including auditing payment; investigating and resolving payment disputes and responding to participant inquiries about payments;

    - Medical necessity reviews or reviews of appropriateness of care of justification of charges;

    - Utilization review, including precertification, pre-authorization, concurrent review and retrospective review; and;

3. **Health Care Operations:** Health care operations means activities that are related to the Plan's functioning as a health plan and provision of health benefits, including without limitation the following:

    - Quality assessment and improvement activities;

    - Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

    - Evaluating health care provider and health plan performance;

    - Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

    - Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, and development or improvement of payment methods or coverage policies;

    - Business management and general administrative activities of the Plan, including without limitation management activities relating to the implementation of and compliance with HIPAA, or customer service including the provision of data

analyses for policy holders, plan sponsors or other customers;

- Resolution of internal grievances; and
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest if it is a covered entity under HIPAA or, following completion of the sale or transfer, will become a covered entity.

Required Uses and Disclosures of PHI

The Plan may use and/or disclose PHI, without the consent or authorization of the individual to which the PHI relates, in the following situations:

1. Whenever required by law, such as responding to a subpoena, a discovery request or a court order;
2. Responding to public health authorities authorized to collect or receive information to help prevent or control disease, injury or disability, to report problems with products or to notify users of product recalls;
3. Responding to public health; social service or protective service agencies to report child abuse, neglect, or domestic violence;
4. Responding to an employer's request for medical information in connection with worker's compensation or similar programs;
5. Responding to a coroner, medical examiner or funeral director to identify a deceased person, determine the cause of death or assist them in carrying out their duties;
6. Responding to a public health oversight agency for certain oversight activities such as audits, investigations, inspections, licensure and disciplinary actions against providers;
7. Responding to law enforcement officials in connection with law enforcement activities, such as investigating criminal conduct or victims of crime or in emergency circumstances;
8. Responding to inquiries from correctional institutions or lawful officials having custody of an inmate if necessary to protect the health of the inmate or other inmates and employees at the correctional institution;
9. Responding to requests from health research agencies, whether privately funded or funded by government, subject to conditions;
10. When necessary to prevent or lessen a serious and imminent threat to the health and safety of an individual;
11. Responding to an authorized federal official in connection with the protection of the President or other authorized persons or foreign heads of state, or for national security activities authorized by law;
12. Responding to organ procurement organizations for cadaveric organ, eye or tissue donation purposes; and
13. Responding to requests by HHS to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures Requiring an Opportunity to Agree or Object

The Plan may disclose to a participant's family member, relative, close personal friend or other person identified by the participant, PHI that is directly related to their involvement with or payment for the participant's health care. The participant must be informed in advance of any such disclosure and given an opportunity to agree or to prohibit or restrict the disclosure, except that if the Plan is unable to do so because of the participant's incapacity or emergency circumstances and the Plan decides that disclosure is in the participant's best interest, the Plan may disclose PHI directly related to the participant's health care to such person.

Uses and Disclosures Requiring Written Authorization

The Plan may use and disclose PHI with respect to an individual to the extent permitted by the individual's written authorization that is valid under HIPAA.

Disclosures of PHI by Plan to Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor and permit a health insurance issuer for the Plan to disclose PHI to the Plan Sponsor, for the purpose of carrying out administrative functions for the Plan, subject to the following requirements:

1. The Privacy Notice for the Plan must include a

   statement regarding the permitted disclosures of PHI by the Plan or a health insurance issuer for the Plan to the Plan Sponsor in accordance with the provisions of this Article;

2. The Plan Sponsor must provide a written certification to the Plan that the Plan documents have been amended to permit the disclosure of PHI by the Plan or a health insurance issuer for the Plan to the Plan Sponsor, and to incorporate the following provisions with which the Plan Sponsor must agree to comply:

    a. The Plan Sponsor shall not use or further disclose PHI received from the Plan or health insurance issuer for the Plan in a manner that is inconsistent with the privacy or security standards under HIPAA and other than as permitted or required by this Section or as required by law;

    b. The Plan Sponsor shall bind any agent, including a subcontractor, who receives PHI from the Plan Sponsor to the same restrictions and conditions that apply to the Plan Sponsor with respect to the use and disclosure of such PHI;

    c. The Plan Sponsor shall not use or disclose PHI for employment-related actions or decisions, or in connection with any of its other benefits or employee benefit plans unless authorized by the individual to whom the PHI relates;

    d. The Plan Sponsor shall report to the Plan any use or disclosure of PHI of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section;

    e. The Plan Sponsor shall permit an individual to inspect and copy his own PHI, and to request and receive an accounting of the disclosures of his PHI, to the extent required under HIPAA;

    f. The Plan Sponsor shall make available to an individual his own PHI for amendment and shall incorporate any amendments to the PHI to the extent required under HIPAA;

    g. The Plan Sponsor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to HHS for purposes of determining the Plan's compliance with HIPAA;

    h. To the extent feasible, the Plan Sponsor shall return or destroy all PHI received from the Plan that it still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, or if such return or destruction is not feasible, it shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

    i. The Plan Sponsor shall establish and maintain adequate separation between it and the Plan, as described in the following section.

3. The Plan Sponsor agrees that if it creates, receives, maintains or transmits E-PHI (other than enrollment/disenrollment information, summary health information and information disclosed pursuant to a HIPAA compliant authorization) on behalf of the Plan, it will (a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of such E-PHI as required by the security standards under HIPAA; (b) ensure that the adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate Security Measures; (c) ensure that any agent or subcontractor to whom it provides E-PHI agrees to implement reasonable and appropriate Security Measures to protect the E-PHI as required by HIPAA; and (d) report to the Plan any Security Incident involving E-PHI of which the Plan Sponsor becomes aware. The terms, "Security Measures," "Security Incident," and "Information System" will have the meaning set forth in the security regulations under HIPAA.

Adequate Separation Between Plan and Plan Sponsor

Only the following employees, classes of employees or other persons under the control of the Plan Sponsor may be given access to PHI: Director, Pension and Contributions Manager, Claims Manager, Controller, Strategic Operations Manager, Information Technology Manager, Assistant to the Director, Job Control Staff, Accounting Department Staff, Electronic Data Coordinator, Dependent Records Coordinator, Claims Department Staff, Mail Clerk, and Receptionist. The access to and use of PHI by the designated employees, classes of employees and other persons shall be restricted to the administrative functions performed by them for the Plan.

Effective Mechanism for Resolving Non-Compliance Issues

The Plan Sponsor shall establish and maintain at all times an effective mechanism such as disciplinary sanctions, for resolving any issues of non-compliance with the restrictions and limitations applicable to the disclosure and use of PHI as set forth in this Article, by the persons designated by the Plan Sponsor for authorized access to PHI disclosed by the Plan.

Exceptions for Disclosure of PHI

The Plan or a health insurance issuer for the Plan may disclose the following information, in the circumstances noted, to the Plan Sponsor without regard to compliance with this Section:

1. Summary health information requested by the Plan Sponsor for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan, or for modifying, amending, or terminating the Plan; or

2. Information on whether an individual is participating in the Plan, or is enrolled in or dis-enrolled from a health insurance issuer offered by the Plan; and

3. PHI as and when permitted by the individual to whom it relates pursuant to a valid authorization under HIPAA.

The Plan's Legal Duties with Respect to Privacy

Plan's Obligation to Maintain Privacy Practices and Right to Change Privacy Practices and Notice:

The Plan is required by law to maintain the privacy of your PHI and to provide you, upon request, with a copy of the Privacy Notice.

The Plan must abide by the terms of the Privacy Notice; however, it reserves the right to amend the Privacy Notice and its privacy practices at any time, and to apply such changes to all PHI that it maintains, even if created or received prior to the change. If there is a material change to the permitted or required uses and disclosures of PHI, your privacy rights, the Plan's legal duties or any other privacy practice described in the Privacy Notice, the change will not be implemented until a revised Privacy Notice has been provided to all individuals then covered by the Plan, via first class mail, within 60 days of the effective date of the material change.

Minimum Necessary Standard:

Whenever the Plan uses or discloses PHI or requests PHI from another covered entity, it will make reasonable efforts not to use, disclose or request more than the minimum necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. The "minimum necessary" standard will not, however, apply to the following: (1) disclosures to or requests by a health care provider for treatment; (2) disclosures to you; (3) disclosures to the HHS; (4) uses or disclosures required by law; and (5) uses or disclosures required for the Plan's compliance with the federal privacy regulations.

De-Identified Information:

The Plan can use and disclose de-identified information freely as this type of information is not subject to the privacy requirement. De-identified information is information that does not identify an individual and for which there is no reasonable basis to believe that it can be used to identify an individual.

ACA Compliant

The Affordable Care Act (ACA), Section 1557, that was signed into law in 2010 requires most health plans to state whether or not they are compliant with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Pipeline Industry Benefit Fund complies with the ACA law.

Grandfathered Status

The Board of Trustees for the Pipeline Industry Benefit Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act.) As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Examining and Obtaining Additional Plan Documents

You may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

- Trust Agreement and amendments
- Collective Bargaining and Participation Agreements
- Plan documents and all amendments
- Annual Report
- Form 5500 and required attachments
- List of contributing Employers
- A copy of the Plan's comparative analysis of non-quantitative treatment limitations for mental health and substance use disorder benefits
- Documents under which the Plan was established or operated

You may also obtain copies of these documents by making a written request to the Fund Office and paying the copying fee. You should ask what the charge will be before requesting copies.

General Definitions

ACA
The Affordable Care Act (ACA) is legislation passed by the 111th Congress and signed into law in March 2010 that changed how Americans enroll in and receive health care coverage. The legislation is overseen by the United States Department of Health and Human Services.

Accident
The term Accident means bodily injury caused by an unexpected incident, which is the direct cause, independent of disease or bodily infirmity, of the loss sustained by the covered person.

Adverse Benefit Determination
An Adverse Benefit Determination is any denial, reduction, termination of or failure to provide or make payment for a benefit (either whole or in part). It will also include, for a "Disability Claim," a cancellation or discontinuance of coverage for the disability benefit with a retroactive effect, other than for nonpayment of a required contribution.

Calendar Year
The term calendar year means that period commencing at 12:01 AM standard time on the date the eligible person first becomes eligible and continuing until 12:01 AM standard time on the next following January 1. Each subsequent calendar year will be the period from 12:01 AM standard time on January 1 to 12:01 AM standard time on the next following January 1.

Certificate of Creditable Coverage
A statement issued by a group health plan or issuer or insurance carrier which includes the date coverage under that plan, policy or arrangement began and ended and the date any waiting period began (effective dates of coverage by a health insurance provider).

Claim
A Claim is a request for a benefit made by a claimant or provider in accordance with the Plan's claims and appeal procedures.

Contributing Employer
A company which does business under the National Pipe Line Agreement or National Distribution Agreement or a Participation Agreement and which makes monetary contributions to PIBF work for performed by its employees on the jobs covered by, and in accordance with the requirements of, any of these agreements.

Deductible
This is an amount of covered charges that each covered person must first incur and pay out-of-pocket during a calendar year before his/her covered charges that are incurred for the remainder of the calendar year will be payable under PIBF.

Eligible Employee
An Eligible Employee is any Employee who has met the eligibility requirements and is eligible for benefits under the Plan. The term "Eligible Employee" may also be referred to as the "Member" within this booklet.

Eligible Dependent
An "Eligible Dependent" is a Dependent of the Employee who meets the guidelines set forth in the Dependents Eligibility Section and qualifies for coverage under the rules set forth in the Plan.

E-PHI
E-PHI means PHI that is transmitted by or maintained in electronic media, limited to E-PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan. Electronic media includes (a) electronic storage media such as memory devices in computers (hard drives) and removable/transportable digital memory medium (magnetic tape or disk, optical disk or digital memory card); and (b) transmission media used to exchange information already in electronic storage media, such as the internet, extranet, leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

Explanation of Benefits (EOB)
The statement that a participant or provider receives that explains how a claim is processed or paid according to the health insurance or plan under which the claim is made.

Family & Medical Leave/Family and Medical Leave Act of 1993 (FMLA)
"Family and Medical Leave" means a family or medical leave of absence, intermittent leave, or leave on a reduced schedule, taken under the Family and Medical Leave Act of 1993 ("FMLA"), its regulations as amended, and as determined and certified by an Employer pursuant to FMLA and PIBF's FMLA policies and administrative procedures.

Grandfathered
A grandfathered health plan can preserve certain basic health coverage that was already in effect when the ACA was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

HIPAA means the Health Insurance Portability & Accountability Act of 1996 and corresponding regulations as amended from time to time. HIPAA provides portability, special enrollment and non-discrimination rules that apply to group health plans such as this Plan. HIPAA also has standards for the privacy and security of health information and the standardized exchange of health plan data. These rules limit the ways in which health plans, such as PIBF and health care providers may use and disclose PHI. HIPAA also gives participants and beneficiaries rights with respect to PHI.

HHS

The United States Department of Health and Human Services.

Hospital

A legally constituted Hospital will be any institution, which meets ALL of these requirements:

- Maintains permanent and full-time facilities for bed care of resident patients.
- Has a doctor in regular attendance.
- Continuously provides 24-hour-a-day nursing service by registered nurses.
- Is primarily engaged in providing diagnostic and therapeutic facilities for the medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, rehabilitation center, mental institution, a place for the aged, a place for drug addicts or a place for alcoholics.
- Is operating lawfully in the jurisdiction where it is located.

Illness

An illness is a disease, disorder, or condition, which requires treatment by a Licensed Medical Provider.

Licensed Medical Provider

A Licensed Medical Provider is a legally licensed physician, licensed to practice medicine and perform surgery and shall include a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, and Doctor of Chiropractic. Coverage will be allowed for services provided by licensed alternate medical providers including Physician's Assistants, Nurse Practitioners, Psychologists, and Midwives.

Medically Necessary

Services or supplies which are appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition; and meet the standards of good medical practice within the medical community in the service area; and are not considered experimental, investigational or cosmetic; and are not primarily for the convenience of the member or a provider and are the most appropriate level of service which can safely be provided.

Michelle's Law

On October 9, 2008, President George W. Bush signed Michelle's Law (Public Law 110-381) to become effective for plan years that begin after October 9, 2009. Generally, this law requires group health plans and health insurers to provide up to one year of extended coverage to college students who are dependents who would otherwise lose health coverage when they take a medically necessary leave of absence.

PHI

Protected Health Information, which is individually identifiable health information that is created or received by the Plan in any form (oral, written, electronic) that relates to a participant's past, present, or future physical or mental health or condition, within the meaning of HIPAA.

Plan Sponsor

Board of Trustees in their role as sponsor of the Plan.

Post-Surgical

Post-surgical refers to a single continuous course of treatment following an open surgical procedure, an invasive surgical procedure or as part of the treatment plan for a closed fracture.

Pre-Admission Certification

Pre-Admission Certification is a certification obtained from the Plan's Utilization Review Provider prior to any in-patient hospital admission or obtained within 48 hours following an in-patient emergency admission.

PPO Plan

PPO Plan is the Participating Provider Option Plan through Blue Cross & Blue Shield of Illinois. Participating or PPO provider's (also referred to as Network Providers) have agreements with BCBS to provide services to PIBF participants at contracted rates.

Qualified Medical Child Support Order (QMCSO)

Qualified Medical Child Support Order (QMCSO) is any medical child support order (must be a court judgment, decree or order, including a court's approval of a domestic relations settlement agreement) or National Medical Support Notice that qualifies as a QMCSO within the meaning of ERISA Section 609(a). A copy of the Plan's QMCSO procedures is available from the Plan Administrator without charge. If PIBF receives a

medical child support order or National Medical Support Notice, it will, as soon as administratively possible, notify the affected Eligible Employee and each alternate recipient covered by the order or Notice of the Plan's procedures for determining if it qualifies as a QMCSO.

Reasonable Expenses Incurred

A Reasonable Expense incurred is the usual and customary fee or charge for covered services and for covered supplies furnished in the area where such services or supplies are rendered, provided that these services and supplies are recommended and approved by a Licensed Medical Provider. Reasonableness is determined by comparisons with fees and charges by other providers for similar services and supplies in the same geographical area. In any event, a Reasonable Expense Incurred will not exceed the lowest of the following: the provider's customary charge or the provider's actual charge.

Reimbursement Agreement

A signed agreement between the covered individual and PIBF promising reimbursement to PIBF for reasonable expenses that the plan has already paid for which may subsequently be paid by a third party source.

Routine Services

Routine Services are services and procedures performed at the patient's request or a provider's request without a diagnosis of injury or illness and not considered necessary for the treatment of a specified medical condition.

Security and/or Privacy Officer

Individual(s) responsible for all established HIPAA security measures and PHI privacy requirements.

Pipeline Industry Benefit Fund | 4845 S. 83rd E. Ave. | Tulsa, Oklahoma 74145-6974 | (918) 280-4800 | Fax (918) 280-4899

Plan benefits are constantly being improved. For the latest version of our health plan benefits, please visit our website: www.pibf.org