Pipeline Industry Benefit Fund: Plan 1, Active & COBRA

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

Coverage Period: 01/01/2026-12/31/2026

Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pibf.org or call 1-918-280-4800. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.pibf.org or call 1-918-280-4800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** person/**$1,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. Stand-Alone medical benefits are covered before you meet your **deductible**.	This plan covers some items and services even if you haven't yet met the **deductible** amount, but a co-insurance may apply. For example, this plan covers certain Stand-Alone benefits without cost-sharing, and before you meet your **deductible**, such as Chiropractic, Non-Surgical Physical Therapy, and Sterilization Benefit (member or dependent spouse only). See a list of covered Stand Alone Benefits at https://pibf.org/pibf-summary-plan-description-booklet/.
Are there other deductibles for specific services?	Yes. **$100** person/**$200** family for prescription drug coverage. **$100** person dental. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For participating providers **$5,000** per person For non-participating providers **$7,500** per person	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.pibf.org or call **1-918-280-4800** for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No co-pay 20% co-insurance	30% co-insurance	——————none——————
	Specialist visit	No co-pay 20% co-insurance	30% co-insurance	——————none——————
	Preventive care/screening/ immunization	No co-pay 20% co-insurance	30% co-insurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No co-pay 20% co-insurance	30% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No co-pay 20% co-insurance	30% co-insurance	——————none——————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pibf.org	Generic drugs	$5 minimum co-pay; or 30% co-insurance at retail. 20% co-insurance for mail order	30% co-insurance	31-90 day supply (retail and mail). If generic is available and you choose a preferred brand, a penalty may apply resulting in additional cost to you.
	Preferred brand drugs	$5 minimum co-pay; or 30% co-insurance at retail. 20% co-insurance for mail order	30% co-insurance	31-90 day supply (retail and mail). If generic is available and you choose a preferred brand, a penalty may apply resulting in additional cost to you.
	Non-preferred brand drugs	$5 minimum co-pay; or 30% co-insurance at retail. 20% co-insurance for mail order	30% co-insurance	31-90 day supply (retail and mail). If generic is available and you choose a preferred brand, a penalty may apply resulting in additional cost to you.
	Specialty drugs	$5 minimum co-pay; or 30% co-insurance at retail. 20% co-insurance for mail order	30% co-insurance	30 day supply (retail and mail). If generic is available and you choose a preferred brand, a penalty may apply resulting in additional cost to you.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	30% co-insurance	——————none——————
	Physician/surgeon fees	20% co-insurance	30% co-insurance	——————none——————

* For more information about limitations and exceptions, see the plan or policy document at www.pibf.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% co-insurance	20% co-insurance	——————none——————
	Emergency medical transportation	20% co-insurance	20% co-insurance	——————none——————
	Urgent care	20% co-insurance	30% co-insurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	30% co-insurance	You may incur additional cost if pre-certification for an in-patient hospital stay is not obtained.
	Physician/surgeon fees	20% co-insurance	30% co-insurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	30% co-insurance	Marital/group counseling - Not covered.
	Inpatient services	20% co-insurance	30% co-insurance	You may incur additional cost if pre-certification for an in-patient hospital stay is not obtained.
If you are pregnant	Office visits	20% co-insurance	30% co-insurance	Coverage limited to member or spouse.
	Childbirth/delivery professional services	20% co-insurance	30% co-insurance	Coverage limited to member or spouse.
	Childbirth/delivery facility services	20% co-insurance	30% co-insurance	Coverage limited to member or spouse.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	30% co-insurance	——————none——————
	Rehabilitation services	20% co-insurance	30% co-insurance	——————none——————
	Habilitation services	Not covered	Not covered	Limited coverage for treatment of developmental delay.
	Skilled nursing care	20% co-insurance	30% co-insurance	——————none——————
	Durable medical equipment	20% co-insurance	30% co-insurance	——————none——————
	Hospice services	20% co-insurance	30% co-insurance	——————none——————
If your child needs dental or eye care	Children's eye exam	20% co-insurance after first $200	Not applicable	Limited to dependent children under the age of 19 and based on reasonable and necessary services.
	Children's glasses	20% co-insurance after first $200	Not applicable	Limited to dependent children under the age of 19 and based on reasonable and necessary services.
	Children's dental check-up	No charge	No charge	Limited to 1 visit every 6 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Infertility treatment	• Ambulance transport for convenience
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Habilitation services	• Private-duty nursing	• Experimental treatment or clinical trials

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Hearing aids (Active member only)	• Routine eye care (Adult)
• Chiropractic care	• Most coverage is provided outside the United States. See www.pibf.org or call 1-918-280- 4800	• Routine immunizations
• Dental care (Adult)		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [Oklahoma, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: www.pibf.org or by calling 1-918-280-4800.

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

Does this plan meet the Minimum Value Standards? [Yes]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-918-280-4890

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-918-280-4890

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-918-280-4890

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-918-280-4890

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

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About these Coverage Examples:

* For more information about limitations and exceptions, see the plan or policy document at www.pibf.org

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, co-payments and co-insurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$600
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Prescription drugs
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Co-payments	$0
Co-insurance	$2420
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3020**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$600
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Co-payments	$0
Co-insurance	$1000
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1600**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$600
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Co-payments	$0
Co-insurance	$440
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1040**

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