

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: 01/01/2021-12/31/2021

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, www.pibf.org or by calling 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/wp-content/uploads/SPD2019.pdf
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	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.
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	30% co-insurance	—————none—————
	Emergency medical transportation	20% co-insurance	30% 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	Substance abuse - 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. Substance abuse - Not covered
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

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

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
- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Substance use disorder
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids (Active member only)
- Most coverage provided outside the United States. See www.pibf.org or call 1-918-280-4800
- Routine eye care (Adult)
- Routine immunizations
- Non-emergency care when traveling outside the U.S.

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, kwijigo 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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* For more information about limitations and exceptions, see the [plan](#) or policy document at www.pibf.org

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Co-payments	\$0
Co-insurance	\$2420
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Co-payments	\$0
Co-insurance	\$1000
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Co-payments	\$0
Co-insurance	\$440
<i>What isn't covered</i>	
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.