Pipeline Industry Benefit Fund: Plan 3, Retiree w/MC Plan

Coverage Period: 01/01/2018 – 12/31/2018

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** Supplement

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.pibf.org or by calling 1-918-280-4800.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$250** individual, **$500** family for prescription drug coverage. **$500** individual, **$1,000** family for in-patient hospital service. 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. 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**.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000**	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	No.	This plan treats **providers** the same in determining payment for the same services.
Do I 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.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Questions: Call 1-918-280-4800 or visit us at www.pibf.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.pibf.org or call 1-918-280-4800 to request a copy.
Language Access Services: Pipeline Industry Benefit Fund provides free language services to people whose primary language is not English. If you need these services, call 1-918-280-4890.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- Your cost sharing does not depend on whether a **provider** is in a network.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
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	Not applicable	Your plan follows Medicare guidelines
	Specialist visit	No co-pay 20% co-insurance	Not applicable	Your plan follows Medicare guidelines
	Other practitioner office visit	No co-insurance for chiropractor. No coverage for acupuncture	No co-insurance for chiropractor. No coverage for acupuncture	Payment limited to $25 per visit and $500 per calendar year for chiropractic service. $100 per calendar year for x-rays by chiropractor. No coverage provided for acupuncture.
	Preventive care/screening/immunization	No co-pay 20% co-insurance	Not applicable	Your plan follows Medicare guidelines
If you have a test	Diagnostic test (x-ray, blood work)	No co-pay 20% co-insurance	Not applicable	Your plan follows Medicare guidelines
	Imaging (CT/PET scans, MRIs)	No co-pay 20% co-insurance	Not applicable	Your plan follows Medicare guidelines

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www. pibf.org.	Generic drugs, Preferred brand drugs, Non-preferred brand drugs	$5 minimum co-pay; or 30% co-insurance at retail. 20% co-insurance for mail order.	30% coinsurance	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% coinsurance	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% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Physician/surgeon fees	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
If you need immediate medical attention	Emergency room services	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Emergency medical transportation	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Urgent care	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Physician/surgeon fee	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Mental/Behavioral health inpatient services	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Substance use disorder outpatient services	Not covered	Not covered	——————none——————
	Substance use disorder inpatient services	Not covered	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not applicable	Coverage limited to member or spouse
	Delivery and all inpatient services	20% coinsurance	Not applicable	Coverage limited to member or spouse

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Rehabilitation services	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Habilitation services	Not covered	Not covered	————————none————————
	Skilled nursing care	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Durable medical equipment	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
	Hospice service	20% coinsurance	Not applicable	Your plan follows Medicare guidelines
If your child needs dental or eye care	Eye exam, glasses	Not covered	Not covered	Retiree plan does not include routine vision coverage.
	Dental exam, cleaning	Not covered	Not covered	Retiree plan does not include dental coverage.
	Other dental services (x-rays, fillings, extractions, etc…)	Not covered	Not covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Substance use disorder
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic care
- Most coverage provided outside the United States. See www.pibf.org or call 1-918-280-4800
- Non-emergency care when traveling outside the U.S.
- Routine immunizations

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-918-280-4800. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Fund Director at 1-918-280-4800.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,472
- **Patient pays** $2,068

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$700
Copays	0
Coinsurance	$1,368
Limits or exclusions	$0
Total	**$2,068**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	0
Coinsurance	$1,030
Limits or exclusions	0
Total	**$1,280**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.